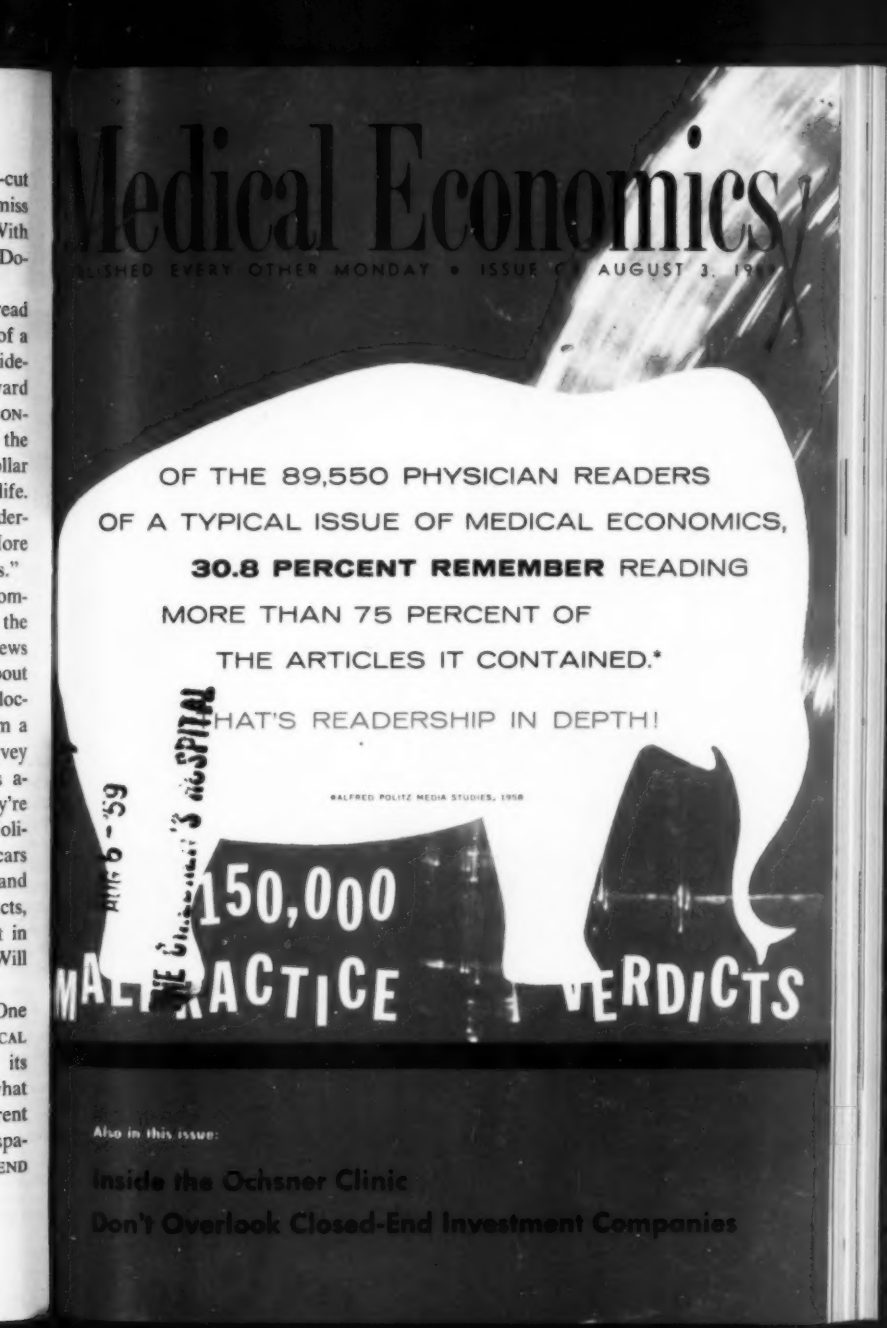

Medical Economics
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OF THE 89,550 PHYSICIAN READERS
OF A TYPICAL ISSUE OF MEDICAL ECONOMICS,
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HAT'S READERSHIP IN DEPTH!
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AUG 6 - '59
150,000
MAL RACTICE VERDICTS
Also in this issue:
Inside the Ochsner Clinic
Don't Overlook Closed-End Investment Companies

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Medical Economics

PUBLISHED EVERY OTHER MONDAY • ISSUE OF AUGUST 3, 19



why you can expect more $150,000 MALPRACTICE VERDICTS

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XUM

fast *welcome relief of spasm and pain is continuously reported in functional G-I disorders, such as irritable, spastic colon syndrome; peptic ulcer; biliary dyskinesia; pylorospasm; and infant colic.*

sure *relief can be expected . . . even in patients where other antispasmodics have failed.*[1-3]

direct *dual antispasmodic action is specific to the G-I tract. Spasm pain is relieved by direct relaxation of the smooth muscle and postganglionic parasympathetic nerve blockage.*

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1. Chamberlain, D. T.: Gastroenterology *17*:224, 1951. 2. Hock, C. W.: J. M. A. Ga. *43*:124, 1951. 3. Derome L.: Canad. M. A. J. *69*:532, 1953. 4. Cholst, M., Goodstein, S., Berens, C., and Cinotti, A.: J. A. M. A. *166*:1276, 1958.

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Medical Economics

NEWS BRIEFS

NEED A SUBSTITUTE FOR YOUR AIDE while she's on vacation? A growing number of agencies now supply temporary office help for doctors. They charge $2 to $3 an hour, and doctors who've used such a service generally report it's worth the price.

YOU'LL FACE MAXIMUM COLLECTION COMPETITION in the months ahead, latest U.S. data indicate. Installment debt is at an all-time high of $35 billion.

WHERE ARE SURGICAL FEES HIGHEST? An elaborate study by 10 major health insurers shows New York City's are 48% above the national average. San Francisco's are second: 42% above average. Vermont's and Virginia's are lowest: 21% below average. Fees are "average" in Utah and Kansas City, Mo.

IS CASH SAFER THAN STOCKS? Since 1948, the First National City Bank of N.Y. points out, cash has declined 17% in purchasing power. But Standard & Poor's Industrial Stock Average has risen 225%.

XUM

NEWS BRIEFS

RELATIVE VALUE SCALES will soon spread to 3 more states. The medical societies of Conn., Mich., and Minn. are now working out point values for various medical procedures. Such scales are already being used in Ark., Calif., Iowa, Kan., Me., Mont., Neb.

"1 OF EVERY 200 AMERICANS WHO DIE in 1959 will have been murdered," says Dr. LeMoyne Snyder, former Michigan State Police Medicolegal Director. Yet many such deaths will be missed by M.D.s, he adds. His Rx: "a little more informed suspicion on the part of America's medical men."

HAS LABOR GIVEN UP on the Forand bill for this year? A.F.L.-C.I.O. spokesman Nelson Cruikshank recently told the House Ways and Means Committee: "We realize that it may be impossible to secure action this year by both the House...and the Senate...But we strongly recommend that you complete your study...not later than early 1960, so the Senate, too, will be able to act...next year."

IF YOUR CREDIT CARD IS LOST OR STOLEN, put in a fast phone call to the nearest office of the firm that issued it, warns U.S. News & World Report: "You are legally responsible for purchases...by someone who finds your card. But...the companies generally relieve you of further liability once you notify them [it] has been lost or stolen."

G.P.s ARE UNHAPPY about New York State's latest Workmen's Compensation fee schedule. In most cases it pays them $.50 to $1 less than it pays D.O.s.

REPLACE MEDICARE WITH HEALTH INSURANCE, Florida's doctors are urging the Defense Department. They say military dependents' health needs should be met by "a definite insurance plan...with the Government bearing the major expense, and the serviceman participating...to a much lesser extent." Unless the Government makes "satisfactory progress" on such a plan by next spring, Florida's M.D.s warn, they'll stop participating in Medicare.

LIFE-LONG FILE ON TAXPAYERS: I.R.S. officials say they're working on a tape system of compiling "a master file of every taxpayer from the time he first comes on the rolls until the day he dies."

"PATIENTS OF THE LOW-INCOME BRACKET receive medical care costing far more than they ever could receive on a fee-for-service basis." That's the report of doctors who recently studied 3 union-run, industry-supported medical centers in Philadelphia. They fear the centers are having a strong "impact on other low-income groups, who will soon be expecting the same medical services on a fee-for-service basis, or possibly gratuitously in the medical clinics of [local] hospitals."

XUM

NEWS BRIEFS

"WHAT'S THE WORST OFFENSE a doctor's wife can commit against his practice?" this magazine recently asked a nation-wide cross-section of M.D.s. The verdict of more than half the respondents: Loose talk or gossip about his patients.

STOCK MARKET "INSIDERS"—corporate officers and people holding 10% or more of a company's stock—"have been heavy sellers of their own stocks" in recent months, Business Week reports. This trend, it warns, "indicates a good degree of caution as to the high level of stock prices."

"UNETHICAL INVASION," charged Naugatuck Valley (Conn.) G.P.s, when they learned specialists from neighboring Fairfield County were taking yellow-page listings in the valley phone books. The Fairfield County medical society agreed. It has ruled it's henceforth "improper" for members to take listings in an area where they don't have either an office, a residence, or a hospital affiliation.

AIDES WHO WEAR THE PIN of the American Assn. of Doctor's Nurses are still making legal news. The "RDN" pin, ruled illegal in Florida, was changed to "DN." Now Wisconsin's Attorney General says its wearers are trying to "share in the prestige...of professional nursing"; any non-R.N. who says she's a doctor's nurse "violates the Wisconsin statute."

XUM

IMPROVING ON NATURE

A luxurious gift of nature – the wheat field is of more value to man because he has modified it to meet his specific requirements. Such an improvement on nature is also found in the treatment of hypothyroidism. Here the response to Proloid provides a dramatic example of man's ability to improve what nature has provided.

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Equanil

Meprobamate, Wyeth

Wyeth Philadelphia 1, Pa.



Medical Economics

AN INDEPENDENT NATIONAL BUSINESS MAGAZINE FOR PHYSICIANS, AUG. 3, 1959

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Don't Overlook Closed-End Investment Companies . . 75

Though they're far less popular than the open-end mutual funds, they have some distinct attractions of their own for the physician-investor—such as no loading charge and high potential returns. Here's the full story

Expect More $150,000 Malpractice Verdicts 80

A new pattern is developing for placing dollar values on health and human life. It's bad news for doctors. Better get it straight from the judge who set the precedent

How Long Should You Keep Patients' Records? . . . 87

'Permanently' is the prudent lawyer's answer. But you probably can't follow his advice. So here's how to judge when it's safe to weed out your inactive files

Inside the Ochsner Clinic 90

It's called the Mayo Clinic of the South. It brings more people into New Orleans than Mardi Gras. And its doctors believe they've found the best way to practice

More ▶

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It starts as a mild itch to speculate, and worse symptoms quickly follow. But here's a doctor-tested antidote

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The happiest day of her life is likely to be the most expensive day of yours. Don't let it catch you unprepared

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Here are four ways, suggested by some of your colleagues, to get it back on the track without being inhospitable

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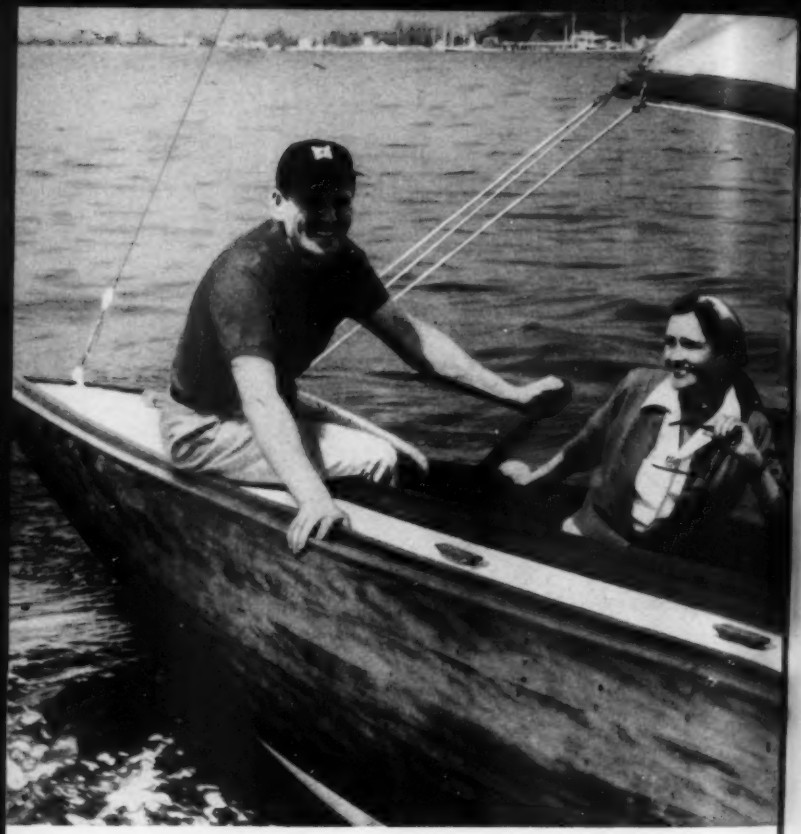
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Which Bills Should You Give to a Collector? ***171***

Those that are five months old may be worth turning over to an agency. Before you decide, give them this test ***More▶***

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Husbands, too, like "Premarin"®

THE physician who puts a woman on "Premarin" when she is suffering in the menopause usually makes her pleasant to live with once again. It is no easy thing for a man to take the stings and barbs of business life, then to come home to the turmoil of a woman "going through the change of life." If she is not on "Premarin," that is.

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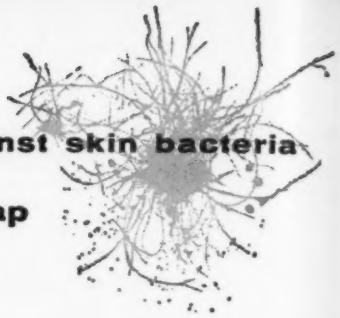
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Dial proved more effective against skin bacteria than any other soap





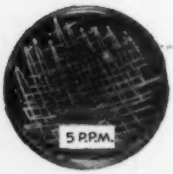
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REFERENCES: 1. Gearren, J.B.: Dis. Nerv. System *20*:66 (Feb.) 1959. 2. Margolis, E.J.; Pauley, W.G.; Cauffman, W.J., and Gregg, P.C.: Scientific Exhibit at the 12th Clinical Meeting of the American Medical Association, Minneapolis, Minn., Dec. 2-5, 1958. 3. Phillips, F.J., and Shoemaker, D.M.: *ibid.* 4. Ayd, F.J., Jr.: Clin. Med. 6:387 (Mar.) 1959.

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Letters

These 'Rich' Doctors

SIRS: I've heard and read so much lately about physicians' wonderful financial condition, their umpteen-thousand-dollar mansions, the mink coats for their wives, their $200,000 life insurance programs, etc. that I could vomit. I can't go to a social gathering without hearing this foolish topic discussed . . . Why must we stand for such nonsense?

Paul S. Watson, M.D.
Kingtree, S.C.

G.P.s vs. Internists

SIRS: . . . As an internist, I don't believe there should be any great conflict between the men in my field and the G.P.s. There need never be! If we enter the sphere of the G.P., it should be only to complement his work, not to compete with him. We must learn to build our practices slowly, to return patients to those referring them, and to see no new patient without giving him a complete physical examination. If he doesn't want this type of care, he should be referred to a G.P.

I don't like the term "family physician" as applied to the internist. I much prefer the term "personal physician."

Leonard P. Caccomo, M.D.
Youngstown, Ohio

How to Check on a Group

SIRS: John R. Sedgwick says the way to evaluate a medical group is to ask the right questions about it. He's right, and I'd add two more questions:

First, what are the group's teaching associations? In our medical group, all members manage to do some clinical teaching. We feel that this is highly important for their continuing medical development.

Second, what are the group's social and community relationships? What about its members' church affiliations and club memberships? Do or don't the doctors' families invite each other over for dinner?

A doctor obviously needs a preview of such things, to judge whether he'd feel at home with a particular group. Yet he himself can't very well ask such personal questions. So our group brings up the subject of social life during the interview.

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REFERENCES: 1. Stewart, B. L., and Rowe, H. J.: J. Am. M. Ass. 160:1221, 1956.
2. Lippman, R. W., et al.: J. Urol., Balt. 80:77, 1958.

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XUM

Letters

we're volunteering the information just for his guidance, and that if he decides to join us his personal life will be his own.

Daniel A. Wilcox, M.D.
Mount Kisco Medical Group
Mount Kisco, N.Y.

SIRS: ... Mr. Sedgwick offers good advice, but I'm skeptical about part of it. He tells with apparent approval of one doctor who weighed the professional qualifications of a group by asking the opinions of taxi drivers and competing neighborhood physicians.

Surely a physician has better methods at his disposal for evaluating his colleagues.

Edwin P. Jordan, M.D.
Executive Director
American Association of Medical Clinics
Charlottesville, Va.

Hospital Harshness

SIRS: For the past three years, my husband has been on the staff of a large hospital. One night recently, he accompanied me there a few hours before my third child was due to arrive. As a staff member, he's entitled to a 25 per cent discount, so he indicated his affilia-



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Letters

tion on the admitting form before he signed it.

This evidently failed to register with the new girl on the desk. She asked us for a deposit of more than half our anticipated hospital bill. My husband told the girl he didn't have his checkbook with him but would be glad to drop in the next afternoon to pay the required amount. She reluctantly agreed.

The baby arrived early that morning. On my lunch tray was a note stating that my deposit hadn't been paid. At about the same time, my husband received a letter from the hospital reminding him a deposit was due.

When he came to visit me a few hours later, he told me he hadn't yet paid the deposit because my doctor had said I could go home in three days. My husband saw no reason to pay a deposit and then settle his bill just a couple of days later.

The next day, we received the same treatment: two notes, one sent to me with lunch and the other mailed to my husband at his office. The tone was much harsher this time.

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3. The Theory of Political Cycles
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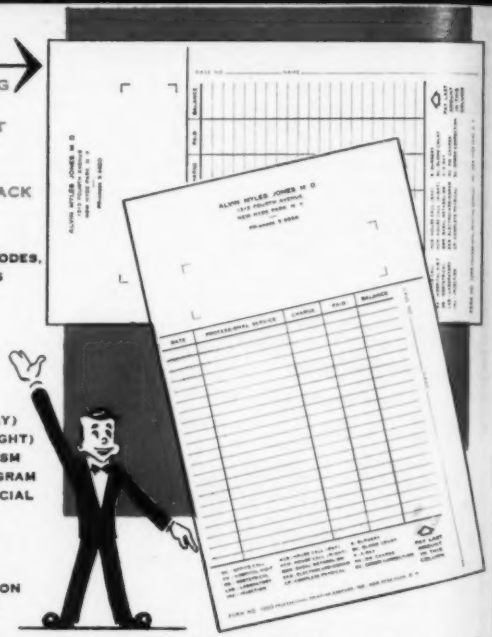
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CP - COMPLETE PHYSICIAL
S - SURGERY
BC - BLOOD COUNT
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EC - ERROR CORRECTION

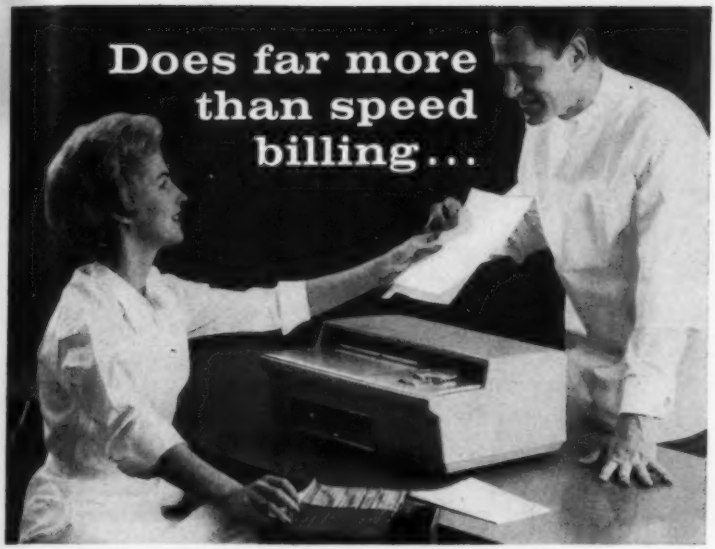


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Letters

Well, I was to leave the day after next, so we still felt there was no reason to pay a deposit. By this time, I rather imagined that the baby would be brought to me next with a grim warning pinned to its diaper.

But the following day's notes merely appeared in the usual manner, via lunch tray and mail. And these little missive notes were downright nasty.

At last the day came for me to leave. My husband called on the house phone to say he was checking out with the cashier. Five minutes later he came up to my room. "What happened about the deposit?" I asked.

"They apologized," he said. "The cashier told me they'd never have sent all the notes if they'd realized I was affiliated. But they say the large deposit—and those little notes if it isn't paid at once—are standard here."

If many other hospitals use such tough policies, it may explain why some patients take so long to pay their doctor bills.

Cynthia Smith
New York, N. Y.

False Medical Hopes

SIRS: In "Do Science Writers Raise False Hopes?" you quote Writer Steven Spencer as saying they don't. Well, maybe some *writers* are guiltless. But as the typical newspaper or popular magazine presents medical articles, dramatic successes are headlined. Qualifications are buried deep in the text—that is, if they're mentioned at all.

Such articles of the past half century constitute a veritable cemetery of dead hopes. Where, for example, is the freezing treatment for cancer so screamingly headlined back in the Thirties?

There are honorable exceptions. But too many popular medical writers or their editors play up the occasional good result and play down the failure.

M.D., Nebraska

Reminder Notices

SIRS: In "How Doctors Feel About Reminder Notices," one doctor complains that "it's too much like advertising." Well, dentists are just as ethical as physicians. And here in the Midwest, few successful dentists are *not* using a reminder system. It's a service their patients demand. And I'm confident that once physicians' patients get used to it, they'll demand it too.

Millard K. Mills
General Manager
Professional Management Midwest
Waterloo, Iowa

END



That wonderful moment when "you're on your own"...

"Good for you!"

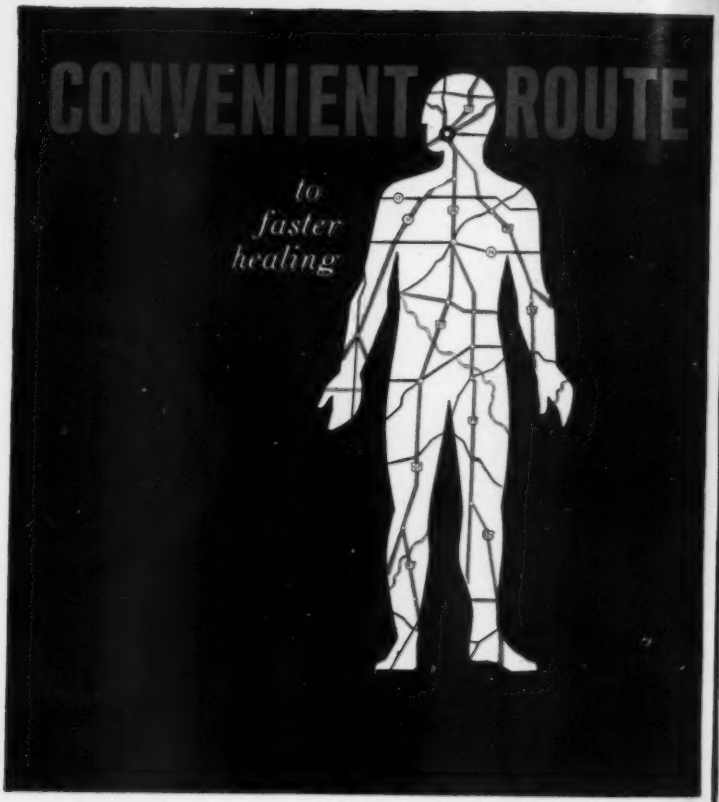
GOOD GOING! Now you've "got the hang of it"... now you know how to water-ski. And later on, it's really great to relax with a good glass of cold beer. No other beverage hits the spot like beer—nothing is so rewarding. And a glass of beer really picks you up too.

Beer Belongs—to the fun of living!



Beer's rich in wonderful healthful things. Nature's own choice barley malt, hops, minerals, and the purest water. Good wholesome beer or ale perks you up—won't let you down.

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News

'Don't Keep Notes to Help The Malpractice Lawyer'

If doctors let tissue committee reports become part of patient-records, they're just making things easy for plaintiffs' attorneys. That's the lesson Dr. Charles Letourneau sees in the arrangement that doctors have at one hospital.


Letourneau

A worried staff man recently told Hospital Consultant Letourneau about his hospital's set-up.

A special sheet is attached to each medical record. On it the five members of the tissue committee indicate whether they think the treatment was "justified, unjustified, questionable, or insufficiently worked up." These opinions are then filed away in the medical-record folder.

"Can this evaluation sheet be subpoenaed by a court?" the doctor asked. Dr. Letourneau's answer: "Any record can be called into court by subpoena."

What should be done to avoid having a tissue committee evaluation sheet show up in court? Dr. Letourneau's advice: Destroy it "when it has outlived its usefulness as a working document." He adds:

"There is no reason for preserving it after it has been acted upon by the medical staff."

'We Can Control Medicine—But Not Its Economics'

Doctors are wasting their time fighting against outside controls and third-party financing of medicine. They should concentrate on building up what no outsider can give or take away from the profession: "the quality of the physician, his status in the community, and the excellence of his medical product."

That's the view of Dr. Norton S. Brown, outgoing president of the New York County medical society. Doctors, he says, can't reverse these trends:

¶ "An over-all drift in society today which will involve greater and greater governmental support of our educational, research, and custodial organizations . . ."

¶ Higher taxes as "more and

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more Federal and state mechanisms...intrude into medical care."

¶ "More group practice, more closed panels, more regimentation, more forms to be filled out, less and less free choice, less and less fee-for-service, and fewer and fewer young men and women willing to enter medical careers with the needed acceptance of service and dedication . . ."

Why can't doctors hope to stop all this? Because, warns Dr. Brown, "A reactionary insistence upon the status quo will serve only to provide better opportunities to exploit the economic problems of health care for the advantage of bureaucracy . . . Organized medicine will not be able to hold back this tide any more effectively than King Canute with respect to the ancient sea."

The only hope lies in "public awareness . . . that 'health' is partly the individual responsibility, not entirely something to be purchased either by fee-for-service or through taxation."

But in any case the physician's value to society needn't be lowered, Dr. Brown continues:

"Regardless of [*More on 42*]

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Control "Morning Sickness" and G.I. Discomfort During Pregnancy . . .

. . . with 'Combid' *Spansule* sustained release capsules. The Combid® combination—10 mg. of Compazine® (prochlorperazine) and 5 mg. of the anticholinergic Darbid® (isopropamide)—provides more than antiemetic activity. 'Combid' reduces g.i. secretion and spasm as well. Clinicians report that bloating, heartburn and cramping, often complicating factors in nausea and vomiting of pregnancy, are effectively controlled with 'Combid' *Spansule* capsules.

Just one 'Combid' Spansule® capsule q12h gives your patient uninterrupted protection—all day and all night. A bedtime dose provides uninterrupted antiemetic activity for 10 to 12 hours. Your patient thus is protected against "morning sickness" the next morning, with ample time for a second dose when necessary. Available: Bottles of 30 capsules. Smith Kline & French Laboratories, Philadelphia.

Now 2 ways to specify Carnation Evaporated Milk infant formula

1 NEW! CARNALAC

...when maximum convenience is desired... New Carnalac is Carnation Evaporated Milk with carbohydrate and Vitamin D added. Diluted 1:1, it provides the typical Carnation Evaporated Milk formula as usually prepared at home.



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for full corticosteroid benefits

new Gammacorten

...a potent, highly effective corticosteroid; profound anti-inflammatory activity, with minimal potential for corticosteroid side effects



this arthritic needed Gammacorten

How this arthritic—and others—responded to GAMMACORTEN is shown on the following pages

With **GAMMACORTEN,** a full measure of corticosteroid benefit can now be brought to patients who have heretofore obtained less than optimal benefit from adrenocorticoid therapy. In practice, the increased activity of **GAMMACORTEN** means greater mobility for the arthritic; greater freedom from attack for the asthmatic; more rapid and more complete resolution of lesions for the dermatologic patient. Unwanted adrenocorticoid effects are less frequent and less severe with **GAMMACORTEN** than with any previous agent. Should side effects occur, they can be managed with greater facility than has previously been possible.

Photographs used with permission of patients.

these arthritics needed Gammacorten

PATIENT W. M., 42, has had rheumatoid arthritis since September 1955. Considerable soreness, pain and stiffness, particularly in shoulders, hands and elbows. Major presenting complaint was pain in the finger joints, with ulnar deviation of the hands and slight contracture of the elbows. Previously treated with prednisone, with partial control of condition.



BEFORE GAMMACORTEN: **cannot flatten hand on table; finger joints extremely swollen; he could not move his hands without pain.**



ONE WEEK AFTER GAMMACORTEN: **W. M. can flatten hand without pain, swelling is considerably reduced. Measurement of grip shows increased hand strength.**



BEFORE GAMMACORTEN: Patient J. D., 58, had arthritis since 1935. At time of examination, shoulder, arm, and finger joints were frozen. J. D. could not button his shirt or perform other functions without help. He had pain all the time. Hands were badly deformed. Unable to move arms away from body; shoulders appeared frozen. Prednisone therapy had brought only slight improvement.



ONE WEEK AFTER GAMMACORTEN: **J. D. has shown remarkable improvement; was able to raise arms to shoulder level without incurring pain.**



ONE WEEK AFTER GAMMACORTEN: **Fingers, although permanently deformed, have regained some usefulness; can button jacket and is even able to extract cigarette from pack and strike match.**

Gammacorten T.M.

(dexamethasone CIBA)

CIBA SUMMIT, N. J.

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for full corticosteroid benefits:

new Gammacorten

this arthritic needed Gammacorten

PATIENT M. S., age 81, at time of first visit was in severe pain and very uncomfortable. Complained of swelling of wrists, legs, various joints; there was pain and stiffness in cervical area and lower spine; pain, swelling and limited motion in the fingers; slight ulnar deviation of the hand. He could not raise his arms above the level of his shoulders.

Treatment and Result: After 36 hours of **GAMMACORTEN** therapy, M. S. had "complete relief." Joint swelling had decreased, pain was almost absent, range of motion had increased dramatically. At the end of the first week of **GAMMACORTEN** he was free of discomfort and able to return to his job as a porter.

BEFORE GAMMACORTEN: M. S. demonstrates position necessary to put on his hat (motion so restricted he could not comb his hair).





ONE WEEK AFTER GAMMACORTEN: **M. S. could put on his hat normally, he could comb his hair; joint function near-normal at end of first week of treatment.**

BEFORE GAMMACORTEN: His fingers were extremely painful and were so swollen that a size 11 jeweler's ring would not fit over his small finger.





ONE WEEK AFTER GAMMACORTEN: **Size 11 jeweler's ring passes easily over previously swollen joint. At end of week, "puffiness" disappeared.**

BEFORE GAMMACORTEN: Hands were so painful, stiff and swollen that M. S. could not flatten hand or extend fingers on flat surface.





ONE WEEK AFTER GAMMACORTEN: **Pain completely subsided. M. S. can flatten hand, extend fingers and flex in normal manner without pain.**

Photographs used with permission of patient.

How to use Gammacorten

in arthritis — An initial dosage of 1.5 to 3 mg. per day (2 to 4 tablets divided into 3 or 4 doses). This dosage should be continued until a satisfactory symptomatic response is obtained — usually within 3 or 4 days. After a favorable response has been obtained, reduce dosage by 1/3 every 2 to 3 days until either maintenance dosage is established or therapy can be discontinued. Satisfactory control can often be maintained with as little as 0.75 mg. to 1.5 mg. per day.

in asthma and allergy — **IN STATUS ASTHMATICUS:** Initial daily dosage of GAMMACORTEN is 7.5 to 10 mg. (10 to 13 tablets divided into 3 or 4 doses). As soon as the acute state is controlled, reduce dosage slowly by 1/3 to 1/4 until a satisfactory maintenance level is reached or until therapy is discontinued.

IN CHRONIC BRONCHIAL ASTHMA: Initial dosage is 1.5 to 3 mg. of GAMMACORTEN per day (2 to 4 tablets divided into 3 or 4 doses). After a satisfactory response has been obtained, decrease dosage by 1/3 every 2 to 3 days until either maintenance level has been determined or therapy can be discontinued. Asthmatics can often be maintained for long periods on as little as 0.75 mg. to 1.5 mg. of GAMMACORTEN daily.

IN INTRACTABLE HAY FEVER: Start with 2 to 3 mg. (3 to 4 tablets divided into 3 or 4 doses) of GAMMACORTEN per day. Symptoms should be promptly relieved; prolonged maintenance therapy is unnecessary for these self-limiting disorders.

in skin disorders — Start with 2 to 3 mg. (3 to 4 tablets divided into 3 or 4 doses) of GAMMACORTEN daily. Satisfactory control is usually obtained at this dosage level. In chronic conditions, dosage should be decreased by 1/3 every 2 to 3 days until either a satisfactory maintenance level has been achieved or therapy can be discontinued. In acute or self-limiting disorders, treatment may be discontinued as soon as control has been obtained.

SUPPLIED: GAMMACORTEN Tablets, 0.75 mg. S/2692 MK-2

T. M.

Gammacorten

(dexamethasone CIBA)

...a potent, highly effective corticosteroid; profound anti-inflammatory activity, with minimal potential for corticosteroid side effects

BEFORE GAMMACORTEN: M. S. could not raise arms above shoulder level; even the degree of motion shown was extremely painful.





ONE WEEK AFTER GAMMACORTEN: **Range of motion and rotation dramatically increased; M. S. could move without pain for the first time in months.**

CIBA SUMMIT, N. J.

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PURE ANTIHISTAMINE ACTION NOW A PHARMACOLOGIC FACT BECAUSE DĪSOMER SHEDS THE MOLECULAR DROSS



NEW...IN THE TREATMENT OF ALLERGIC DISORDERS



- *"...high therapeutic index"*[1]
- *unsurpassed clinical efficacy*
- *highly effective in exceptionally small doses*
- *side effects reduced to placebo level*

Disomer....a major scientific advance in the pharmacology of antihistamines!

DISOMER was described as being *"...as close to a pharmacologically pure form of histamine antagonist as the chemist can produce."*[1] Incorporating the newest knowledge of structure-function relationships, DISOMER comes closest thus far to the therapeutic ideal of pure antihistamine activity. DISOMER represents the *d*-isomer of racemic brompheniramine maleate. In shedding the *l*-isomer a high point in clinical effectiveness is achieved while side effects are reduced to the placebo level.

Therapeutic results have been noteworthy with 88% effectiveness reported.[2] Equally noteworthy is the virtual absence of clinically significant adverse reactions. Indeed, the sole side effect reported was occasional, mild drowsiness in only 5% to 6% of patients.

With DISOMER your allergic patient remains your alert patient while enjoying unsurpassed freedom from allergic symptoms. Ready now for your prescription—DISOMER is available in a variety of dosage forms to fit your patients' individual requirements.

Availability:

DISOMER CHRONOTAB*	6 mg.
DISOMER CHRONOTAB*	4 mg.
DISOMER Tablets	2 mg.
DISOMER Syrup	2 mg. per 5 cc.

Usual dosage:

6 mg. CHRONOTAB	b.i.d.
4 mg. CHRONOTAB	t.i.d.
2 mg. Tablet	q.i.d.
Syrup 1 teaspoonful	q.i.d.

**Chronotab* is White's repeat-action tablet.

References: (1) Gould, A. H. and Long, D. L.: Clinical Pharmacology and Therapeutic Use of Dexbrompheniramine Maleate (Disomer), a new Histamine Antagonist (submitted for publication). (2) Medical Department, White Laboratories, Inc.

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New wide-use dosage form

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Pro-Banthine Tablets (Half Strength) have been especially designed for your prescribing convenience.

This new form provides flexibility of dosage from low levels of one tablet t.i.d. for patients with minimal distress, to one or two tablets every 2 or 3 hours for those with more pronounced symptoms.

Primary indications are gastrointestinal spasm, bladder spasm, maintenance therapy of peptic ulcer and "irritable bowel" syndrome. The lower dosage also has a field of usefulness in smooth muscle spasm of children and geriatric patients.

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PRO-BANTHĪNE®
TABLETS
(HALF STRENGTH)

when your prescription reads—

℞ *Pro-Banthine Tablets (Half Strength)*

—the pharmacist will dispense this new size (7½ mg.)

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Dosage forms:	Pro-Banthine tablets (15 mg.)
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News

Continued from 32

whatever social system obtains, the doctor is the one individual charged directly with the care of the patient. No one else can do this. His position and reputation depend upon this factor rather than upon the definition of the economic system under which he operates."

Too Few Hospital Beds? Study Finds Too Many

One large city has carried out the most exhaustive study to date on hospital bed utilization. Its conclusion: Hospitals and city planners must cooperate in planning the number of beds. That's because it costs almost as much to maintain an empty bed as it does one that's used.

The $200,000 study was carried out by a committee in Cleveland that included four doctors. In a study of 65,000 hospital admissions, they found that it was costing hospitals:

¶ To maintain a bed in use, $9,000 a year.

¶ To maintain an empty bed, about 75 per cent as much, or $6,700.

What's the answer? To plan hos-



added methionine helps avoid diaper rash metabolically... lactose (the sole carbohydrate) minimizes perianal dermatitis... and high unsaturated fatty acid content reduces likelihood of eczema

Easy for mothers... just add water

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Novahistine works better than antihistamines alone

Stuffy, runny noses...swollen, weepy eyes are more effectively relieved with Novahistine. The distinctly additive action of the vasoconstrictor and antihistamine combined in Novahistine relieves allergic symptoms more effectively than either drug alone.

one dose of 2 tablets for day-long or night-long relief.

Each long-acting tablet contains Phenylephrine HCl 20 mg. and Chlorprophenpyridamine maleate 4 mg.

Bottles of 50 and 250 green, film-coated tablets.

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Novahistine LP* LONG-ACTING

*Trademark

pitals in the light of medical need. The committee recommends that hospitals go slow on plans for expansion.

Cleveland hospitals have already reacted. So far, three that were planning to add 400 beds have scaled down the figure to 150.

Why They Balk at Being X-Rayed

If patients begin to ask some suspicious and technical-sounding questions before submitting to X-ray, they're acting on instructions. Again a mass-circulation magazine has been checking up on doctors. It passes the word that "too many physicians . . . are not taking the precautions they should when they use X-ray apparatus."

Redbook magazine conducted "detailed interviews with fifty family physicians across the country" to see if they met standards set up by the American College of Radiology. One doctor surveyed was reported to be so cautious that he had "virtually stopped using X-ray in his practice." But "several . . . had permitted lapses in safety precautions or were uncertain about when—and when not—to use X-ray," says the magazine.

Rather than risk such a slip-up, patients are warned, "your best assurance of safety (especially if you need extensive work) is to have X-rays taken by a specialist in radiology." But with a radiologist or any other doctor, the magazine suggests "some questions [to] ask before undergoing any extensive X-ray procedures":

¶ Does the X-ray equipment have cones and filters?

¶ Does the fluoroscope have a timing device?

¶ Will the doctor use a lead apron (where possible) to shield reproductive organs?

¶ Was the equipment ever checked by a qualified radiation physicist?

¶ Before starting fluoroscopy, will the doctor adapt his eyes to a low-intensity beam by wearing goggles for at least ten minutes?

"If your doctor answers yes to all these questions," says the Redbook report, "he's probably reasonably aware of the dangers of radiation."

U.S. Malpractice Awards Worry the British Too

This country's reputation for big personal-injury suits is beginning to worry even the British. The British Medical Journal advises ship surgeons to make sure their malpractice insurance covers them outside of England.

Why? Because the American

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ACIDTYPES *from the Gelusil Family Album* — **MOTHER**

When this was taken, Mother was lovely and poised — even though in the family way. In the genteel manner of her day, she concealed her condition well, although almost nothing could mask her recurrent "heartburn."

Today pregnancy is no secret. Nor is effective treatment of accompanying gastric upset. You can assure *your* ladies-in-waiting full symptomatic relief . . . prompt, lasting and safe . . . with pleasant-tasting Gelusil, the antacid adsorbent Mother should have had.

Gelusil is all antacid in action . . . contains no laxative . . . does not constipate. Prescribe Gelusil with confidence for every patient's use at home *and* in the hospital. The choice of modern physicians for every antacid need.

GELUSIL®

antacid adsorbent

WARNER

MR. COBB:
And those are the three reasons for prescribing AMPLUS IMPROVED for the control of obesity.

DR. M.:
Mr. Cobb, if you were as convincing with your wife as you just were with me, you wouldn't be here today.

new AMPLUS® improved

(D-AMPHETAMINE + ATARAX® + VITAMINS AND MINERALS)

One capsule half-hour before each meal. Bottles of 100 soft, soluble capsules, this actual size.



MR. COBB DETAILS DR. M.

DR. M.: What's this, nurse? Gordon Cobb, the Roerig detail man, here as a patient? Send him in, please.

MR. COBB: **Don't get the wrong idea about this black eye, Doctor. All I said to the missus was, "Dear, perhaps AMPLUS IMPROVED might help you reduce a little." And WHOMP—**

DR. M.: Well, I can understand her side of the issue, too. I always broach the subject of reducing with utmost finesse.

MR. COBB: **So did I! First I told her that notable progress had been made in anorexigenic agents—as, for example, the addition of vitamins and minerals to d-amphetamine. You remember—that was AMPLUS.**

DR. M.: Naturally. I prescribed it quite frequently. Kept mineral and vitamin requirements up during dieting.

MR. COBB: **OK. So then I mentioned the "improvement" part of AMPLUS IMPROVED—tranquilizing with ATARAX.**

DR. M.: Good addition. ATARAX reduces any undue nervous stimulation.

MR. COBB: **Also reduces the gastric craving because it's antisecretory.**

DR. M.: Gordon, you're mixing business with malaise.

MR. COBB: **Anyway, she hauls off like Dempsey and here I am.**

DR. M.: Mr. Cobb, if you were as diplomatic with your wife as you just were in convincing me to prescribe AMPLUS IMPROVED, you wouldn't be here today.

MR. COBB: **Maybe so, Doctor. But you know the saying, "no pains—no gains."**

DR. M.: True. So here are two prescriptions:
for your "pains"—hot and cold applications;
for your wife's "gains"—AMPLUS IMPROVED.

representing
J. B. Roerig and Company
Mr. Cobb

ROERIG Rx

New York 17, N. Y.
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Science for the World's Well-Being

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tourist could be expensive. Suppose a British ship surgeon should operate on an American. "In the event of a surgical mishap [the doctor] might find himself the defendant to an action for negligence in the [American] courts," says the Journal. "Moreover, they think big on damages in California."

Union Says Fee-Gouging Endangers Health Plan

The argument that doctors are fee-gouging has often been used by labor unions as a reason to set up their own closed-panel plans. But now a union that's in favor of free choice is complaining about what it calls "spectacular overcharges" by private physicians. And it offers specific cases to back up its accusation.

The union is one of the largest in the International Association of Machinists, covering employes at the Douglas Aircraft plant in Santa Monica, Calif. The private-carrier health insurance plan it has negotiated with Douglas gives free choice of physician and covers 80 per cent of medical bills, over and above the $25 deductible. There has been an understanding that





ON THE SPOT TREATMENT

A TOPICAL FUNGICIDE FOR TOPICAL FUNGOUS INFECTIONS

Desenex attacks fungous infections caused by dermatophytes which affect the horny, keratinized layers of the skin.

Athlete's foot is a fungous infection of the skin involving the superficial layers that are not reached by the blood supply. A fungicidal agent, applied directly to these superficial fungous infections, brings the antifungal agent into intimate contact with the invading organism for the most effective method of treatment.

Desenex, a combination of zinc undecylenate and undecylenic acid — an unsaturated fatty acid with an 11-carbon chain — has resulted in more "clinical" cures . . . proved to be the least irritating, and the safest of all potent fungicidal agents.

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PD-66

XUM

doctors' fees will follow the California relative value scale at $5 a point.

But, says Charles H. Jones, union district administrator, "indiscriminate fee-gouging by some . . . doctors" threatens this program. And whatever happens, "doctors in this area will not enjoy the best of public relations," he adds. "A goodly number of doctors are striving for a two-Cadillac status at the expense of hourly employes at the Santa Monica plant."

Two of the "spectacular overcharges" the I.A.M. reports:

¶ One employe was charged $3,200 by two doctors for an eye operation. After an I.A.M. complaint to the medical association, the doctors trimmed off $1,325.

¶ A husband and wife who were both ill were billed $1,625 for twenty-eight days of house calls. The doctor was later persuaded to reduce this by $950.

But, adds the I.A.M., the overcharges that hurt most are "the day-to-day cases" involving $10 or $20 fees, many of which "must come out of the pockets of our union members."

Is the union planning to switch to a panel plan because of its experiences with private physicians? No, says the I.A.M. administrator. The union will "take these cases before the medical association, where we will point out that the regular fee allowed under the health and welfare plan is a fair fee. If relief is not forthcoming, we will take our case to the State Legislature."

Belli Loses: 'Sympathetic' Jury Award Is Thrown Out

Headlines are to be expected from a personal-injury suit involving (1) a $250,000 claim, (2) a young plaintiff who has lost both legs, (3) Melvin M. Belli as plaintiff's attorney, and (4) testimony based on Sodium Amytal—known to laymen as "truth serum."

There was such a case not long ago, and it drew headlines, all right. But the headline writers were busy elsewhere by the time the judge got around to announcing his decision. Yet for doctors, the decision was significant. It illustrates this sometimes-forgotten legal safeguard: A judge can veto a jury's verdict if the jury has obviously acted out of sympathy alone.

Here's how the case developed:

The 29-year-old plaintiff, John W. Freeman, was struck by a train in the Columbus, Ohio, yards of the New York Central Railroad in 1954. He suffered spinal injuries and the loss of his legs.

At the time, Freeman said he

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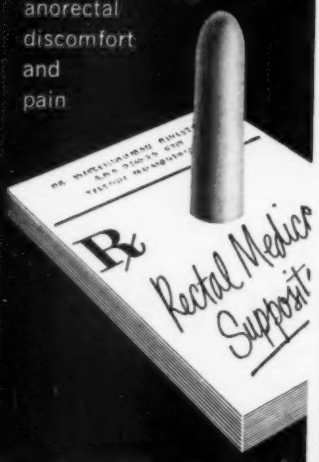
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News

couldn't remember the events leading up to the accident. He admitted that he'd been drinking. But a Columbus internist, Dr. Maurice B. Rusoff, diagnosed Freeman's loss of memory as traumatic retrograde amnesia. The doctor attempted to jog his memory with Sodium Amytal.

After treatment, Freeman said he could remember what had happened before the accident—including, he said, how a railroad man had pushed him onto the tracks.

So Freeman asked $250,000 damages from the railroad. His case in court was based largely on his own "refreshed" recollections. Although the truth serum" issue attracted newspaper interest, Ohio Common Pleas Judge Joseph M. Harter commented: "The evidence relating to treatment of Freeman with Sodium Amytal was, relatively, the least important aspect. . ."

Melvin Belli made what the judge called a "dramatic and sincere" plea for his client. The jury deliberated, then returned an award of $38,345 for Freeman, instead of the $250,000 he'd asked for. To this verdict Judge Harter reacted sharply. Declared the judge:

"If the railroad company was to be held liable at all, the actual damages to Freeman probably should have been to the full amount of his

prayer . . . So it is readily apparent that the jury . . . attempted to do a kind of Solomon's justice [with] a 'token' redistribution of loss (probably through easily understood sympathy) . . . Because of this apparent 'compromise,' I cannot attach a great deal of legal significance to the jury's verdict."

With that the judge re-examined the issues and the evidence, then announced that the railroad clearly was not liable. So the jury's "sympathy" award to the injured man was thrown out.

Lawyer Belli and his associate have appealed.

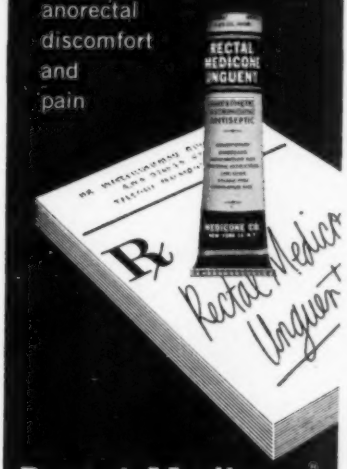
D.O.s on Hospital Staff Now No Bar to Accreditation

If a hospital has been denied accreditation only because it has osteopaths on the staff, chances are it can count on formal accreditation soon. Reason: The American Medical Association no longer forbids M.D.s to practice in hospitals that are required by law to admit D.O.s to the staff.

What's more, the A.M.A. representatives on the Joint Commission on Accreditation of Hospitals have been instructed to consider such hospitals for accreditation "without prejudice."

Says Dr. Kenneth Babcock, director of the Joint Commission: "This means that some 300 hospitals in nine states may be eligible for the first time to apply for accreditation. Up to now, they've

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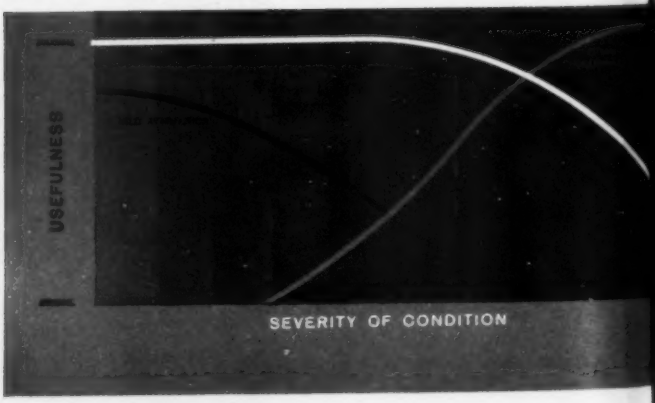
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News

been considered off-limits, even though the D.O.s held staff privileges by virtue of special legislation or court rulings.

"Eligibility of hospitals with osteopaths on their staffs will be an important item on the agenda at the next meeting of the commission."

Here's a Low-Cost Health Insurance Plan for Aides

"I didn't want my trained aides deserting my office for the fringe benefits offered by big industries," says Dr. D. Edward Frank of Sun Valley, Calif. That's why he enrolled his aides in a health plan offered by the American Association of Medical Assistants.* He recommends the same step to any "lone doctor, small group, or clinic" as a way to provide low-cost health insurance for office help.

Dr. Frank has five aides, all under 50 and all A.A.M.A. members. For each of them he sends the Association $112 a year. This pays the aide:

¶ Up to $10,000 (after $100 deduction) for hospital, medical, and surgical expenses.

¶ $200 a month for disability compensation. The payments last for one year in case of sickness and five years in case of accident.

The premiums the doctor pays

*510 N. Dearborn St., Chicago 10, Ill.

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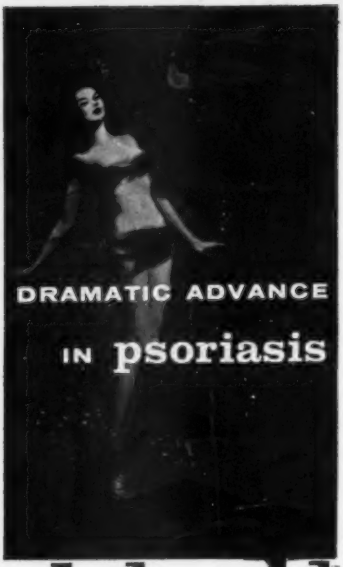
Also, hypotension is minimal and infrequent—a particular advantage in surgical patients.

For immediate effect: Ampuls and Multiple dose vials. Also available: Tablets, Spansule† sustained release capsules, Suppositories and Syrup.

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† T.M. Reg. U.S. Pat. Off.





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SUCCESSFUL RESULTS RANGING TO COMPLETE CLEARING obtained[2,3,4] in patients with: • scalp-to-toe psoriasis • psoriasis of many years' duration • psoriasis involving tender areas.

TREATMENT-FASTNESS HAS NOT OCCURRED

SAFETY: avoids potential hazards of other therapies — mercury, arsenic, steroids, x-ray.

A NOTEWORTHY ADVANCE COSMETICALLY: non-greasy, nonstaining; vanishes on application to the skin. May be used freely on the scalp.

FORMULA: allantoin 2% and special coal tar extract 5% in a lotion base.

SUPPLIED: bottles of 8 fl. oz.

(1) Fiesch, P.: Reported Conf. N.Y. Academy Science May 9, 1958 (In Press). (2) Bleiberg, J., and Saltzman, J. A.: Clin. Med. 5:485 (Apr) 1958. (3) Bleiberg, J.: Reported Conf. N.Y. Academy Science May 9, 1958 (In Press). (4) Clyman, S. G.: Reported Conf. N.Y. Academy Science May 9, 1958 (In Press). *Trademark

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News

are fully tax-deductible, of course, as a business expense.

He has even found a way to make the plan cover himself as well. How? By classing himself as his wife's dependent. She's an aide, and all aides can stretch A.A.M.A. coverage to their dependents.

"My relatively high income would ordinarily bar me from getting this kind of major medical coverage with even a $750 deductible," he reports. "But since my wife works in the office and has become a member of A.A.M.A., I am now covered with only a $100 deductible."

Already, two of his aides have benefited under the plan. His secretary received over $2,000 and his nurse $1,300 for medical and surgical expenses. In addition, both were paid $600 in disability benefits. Dr. Frank says the health plan also pays off in better staff morale.

Private M.D.s Invited In on New Plan for Addicts

Private practitioners will be invited to lend a hand at treating narcotics addiction in a new program planned by New York City. The city has an estimated addict population of some 20,000, about 40 per cent of the national total.

Special wards are to be set up at three municipal hospitals for narcotics users of all ages who



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ODORLESS AND TASTELESS • VIRTUALLY NO STING OR BURN • ALMOST IMMEDIATE RELIEF • ACTION LASTS LONGER • NO REBOUND CONGESTION

ADMINISTRATION: In each nostril, not more often than every 4 hours.

Under 2 years – 1 drop 0.05% Pediatric Nasal Drops

2 to 6 years – 1 to 2 drops 0.05% Pediatric Nasal Drops

6 years and over – 2 to 4 drops 0.1% Nasal Solution or 2 to 4 squeezes of 0.1% Nasal Spray

Note: Overdosage may cause deep sleep in infants and young children. When using Tyzine Nasal Spray, it should be held in an upright position.

SUPPLIED: *Nasal Solution*, 1 oz. bottles. *Nasal Spray*, 15 cc. in plastic bottles. *Pediatric Nasal Drops*, 1/2 oz. bottles.

1. Menger, H. C.: New York J. Med. 56:1279, 1956. 2. Pace, W. G.: Mil. Med. 118:34, 1956. 3. Roberts, J. G.: M. Times 84:1232, 1956. 4. Anderson, H. A.: Antibiotic Med. 3:199, 1956. 5. Graves, J. W.: Eye, Ear, Nose & Throat Month. 34:670, 1955. 6. Katrana, N. J.: Illinois M. J. 110:19, 1956. 7. Neistadt, I.: A.M.A. Arch. Otolaryng. 62:143, 1955. 8. Olson, J. A., and Carlozzi, M.: Eye, Ear, Nose & Throat Month. 35:189, 1956. 9. Parish, F. A.: M. Times 82:917, 1954.

SUCCESSFUL IN 95% OF 2,576 CASES[1-9]

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want to break the habit. If they'll submit to voluntary commitment, they can get medical, psychiatric, and rehabilitation care. Members of the visiting staff will take part in the program if they want to.

When the new program gets rolling, it may well be the biggest step against addiction yet taken in this country by a non-Federal agency. Meanwhile, the city will continue to run eight out-patient clinics for narcotics users. But the out-patient approach hasn't been very effective, say health officials.

Radiologists Join Forces In Fight for Recognition

Radiologists across the country are waging a new campaign in their running battle to get all hospitals to bill patients in their names.

The American College of Radiology has ruled that each member must make a "firm request" to his hospital, if it's not already doing so, to include the doctor's name on bills for radiological services. And members are required to file a copy of their letters with the A.C.R.

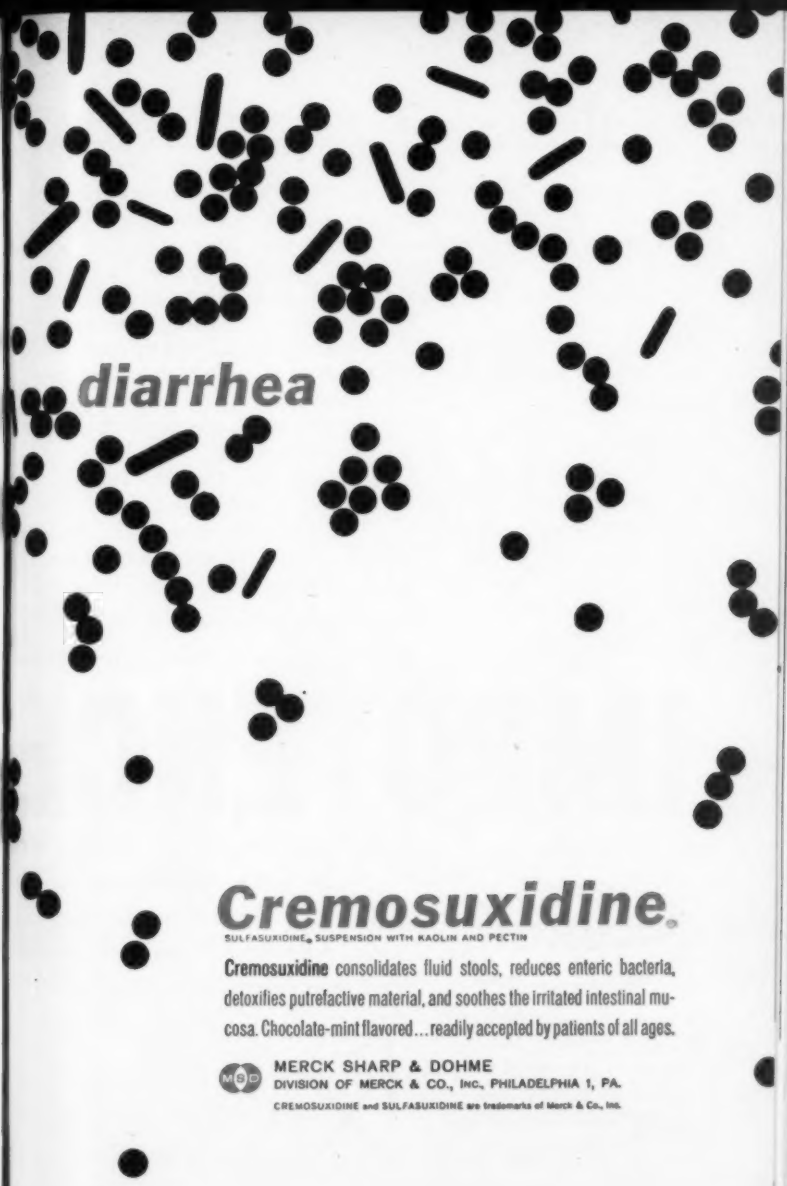
What are the prospects for the campaign's success? Good, says William C. Stronach, A.C.R. executive director. Although less than half of billings are made this way now, he reports that "hospitals are recognizing that it's in their self-interest to attribute charges for medical services to physicians; this tends to eliminate in the public mind an element of spiraling hospital charges that are condemned almost daily in the press."

Doctors Tell Why They Can't Stop to Chat

Why don't physicians converse at length with patients as the old-fashioned family doctor did? A Virginia newspaper sent a reporter to a meeting of the state Academy of General Practice to get an answer to this question. The G.P.s agreed it was a good one, but they had a good answer too.

Said one practitioner: "There's a lot of truth to patients' complaints that they're not offered enough time "to sit down and get to know the doctor." And doctors want to let them talk, he added. But "we're caught in a financial squeeze," he told the Richmond Times-Dispatch. "To give the patient all the time he needs is a bankrupting procedure."

Another G.P. explained how this squeeze affects his own practice: Though gross billings come to $30-40,000 a year, 48 per cent of it pays aides' salaries and office expenses. Another 10 per cent is never collected. The remaining $12-16,000 is pared down by per-



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sonal income taxes and payments on a house-and-office mortgage. "You can see I'm not going to be buying any yachts," he remarked.

And to keep up even this scale of living, he added, he has to see thirty to forty patients a day. So he can't stop long to chat with them.

Cut-Rate Insurance for Safe Drivers Gets a Boost

One company has decided that "safe-driver" insurance is too good to be confined to California. The result could be that eventually all drivers with accident-free records will pay less for auto policies.

The California experiment started on May 1. Under it, 200 sponsoring companies offer a 20 per cent premium discount to drivers with unblemished accident records. Drivers who are held responsible in accidents pay penalty rates that start 10 per cent higher than the "safe driver" pays—and that can climb 150 per cent higher than the discounted rate.

Now The Travelers Insurance Company, one of the nation's five biggest underwriters of auto insurance, wants to offer a similar plan

GLUKOR effective in 85% of cases.[1]
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1. *Gould, W. L.: Impotence, M. Times 84:302 Mar. '56.*
2. *Personal Communications from 110 Physicians.*
3. *Milhoan, A. W., Tri-State Med. Jour., Apr. '58.*

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dramatic results:
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Available: PRESCRIPTION PACKAGE of six single doses. Each unit contains 0.625 Gm. theophylline monoethanolamine. *Indications:* For relief of symptoms of acute or chronic asthma and left ventricular failure ... as directed.

References: 1. Ridolfo, A. S. and Kuhlstedt, K. G., "A Simplified Method for the Rectal Institution of Theophylline," Am. J. M. Sc., 237:585, May, 1959. 2. Hoobler, S., Personal Communications.

Literature on request

C. B. FLEET COMPANY, INC., *Lynchburg, Virginia*

what's
your
corticosteroid
score?

1

rates
highest
in clinically
significant
tests

1
2
3
4

		True	False
1	Both prednisone and corticotropin have at times been reported to produce diuresis in refractory edema due to cardiac disease.		
2	Corticotropin produces hypertrophy of all anatomical zones of the adrenal cortex.		
3	Corticosteroids have a regulatory effect on the weight of the adrenal gland.		
4	The serum concentrations of ascorbic acid and cholesterol both reflect adrenocortical activity.		

Answers appear below

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METICORTEN—1, 2.5 and 5 mg. tablets. Meti,® brand of corticosteroids.

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ANSWERS: 1. True. 2. False—only in the *zona fasciculata* and the *zona reticularis*. 3. False—they affect the weight of the thymus. 4. True.

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in Iowa, Michigan, Minnesota, and Nebraska. And another company's spokesman says: "There'll be a hurry to follow suit if it works."

One Off-the-Record Gripe Closes Polio Clinics

Doctors have sometimes complained that they find their own private patients in line at public polio clinics. But when this happened recently in Connecticut, the complaint:

1. Touched off a controversy that closed down the clinics for a week.

2. Gave local physicians a bad press.

3. Created, as the medical association president puts it, "a tempest in a teapot over a misapprehension."

Newspapers printed a story that the health department in Stratford, Conn., had canceled a series of polio immunization clinics. The health department's reason for the shutdown? Well, hadn't the Fairfield County Medical Association just said that it would expel doctors who volunteered their services for such clinics?

No such thing, retorted the association president, Dr. Payson B. Ayres. How could the health department have got that idea?

Dr. Ayres' answer is that the mix-up seems to have started with an off-hand remark. His story: One doctor at a clinic overheard another doctor complaining that persons who could well afford to pay for the shots were coming to the clinics. There ought to be a regulation, the doctor added, about screening the applicants.

As the listening doctor somehow understood it, such a regulation already existed. And the "regulation" got better as it spread. Finally, says Dr. Ayres, several doctors told the health department they'd be expelled from their medical society if they took part in the clinics.

So the clinics were suspended temporarily. They've since reopened. But not before the newspapers seized their chance to explain the problem to the public. One headline: "Town Cancels Clinics After . . . Physicians Found Own Patients in Line for Injections."

'The Forand Bill Would Help the Wrong People'

An insurance company official says there's one telling argument doctors can use against the Forand bill: It won't help the elderly persons who can least afford their own private health insurance.

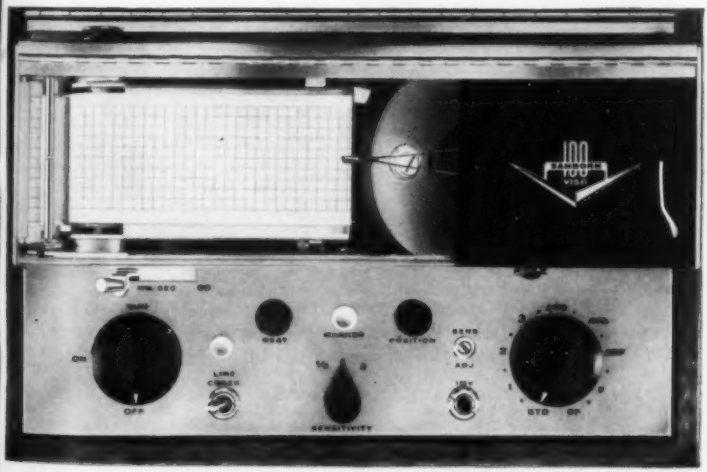
These, says Howard A. Moreen, vice president and secretary of the Aetna Life Insurance Company,



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the most modern electrocardiograph you can own



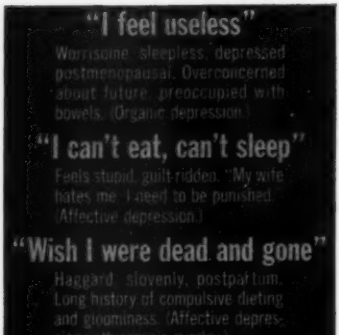
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first report on a new and significant antidepressant

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brand of phenelzine dihydrogen sulfate

the new, rapidly effective office treatment for depression



clinical response: depressed patients usually respond with an elevation of mood within a few days. Self-deprecatory feelings, sadness and ruminative thinking rapidly subside. Recovery generally occurs within 2 to 6 weeks. Depression is lifted without the overstimulation encountered with amphetamines. Clinical trials since 1957 have revealed no toxic effects on blood, liver or kidneys. Side effects are occasional, mild and transient.

Sainz[1] reported that, of his series of 122 patients with depressions, over 80 per cent recovered following Nardil therapy. "Maximum improvement was always noticed not later than five weeks after the onset of therapy."[1]

Thal,[2] as a result of his experience with Nardil in 180 patients, pointed out that 80 per cent of patients with depressions were discharged from the hospital as recovered within 60 to 90 days following treatment with Nardil.

no liver toxicity to date in over 1,000 cases: Nardil has a preferential distribution to the brain—not the liver. Sainz[1] found that Nardil, in 122 depressed patients, was "...less toxic than iproniazid because no hepatic, hemopoietic or central nervous system parenchymatous damage (had) occurred or been foreshadowed." Neither Thal[2] in 180 patients, nor Saunders,[3] saw any toxic effects after careful analysis of liver function tests and blood studies.

indications: Nardil is indicated for the office treatment of depressed patients who are sad, worried, sleepless, anxious; who can't eat, are guilt-

ridden, unkempt; who feel useless and who have gloomy, ruminative thoughts. True (endogenous) depression, affective or organic.

side effects: The occasional side effects which have been reported include postural hypotension, with the expected associated signs, transient impotence, nausea, ankle edema, delayed micturition and constipation. These can be adequately managed by appropriate adjunctive therapy or will abate as dosage is reduced to the maintenance level.

caution: Even though no toxic effects on the liver have been reported with the use of Nardil, as a matter of caution, patients should be carefully followed with liver profile studies and the drug should be withheld or used with extreme care where the patient has a history of liver disease or where liver damage is present. Also, hypotensive patients should be under close medical supervision.

supply: Bottles of 100 orange-coated tablets, each containing 15 mg. phenylethylhydrazine present as the dihydrogen sulfate.

references: **1.** Sainz, A.: The Phrenopraxic Activity of a Non-noxious Antidepressant, Ann. New York Acad. Sc. (in press) 1959. **2.** Thal, N.: Cumulative Index of Antidepressant Medications, Dis. Nerv. System *20*:197 (May) 1959. **3.** Saunders, J. C.; Roukema, R. W.; Kline, N. S., and Bailey, S. d'A.: Clinical Results with Phenelzine, Am. J. Psychiat. (in press) 1959. **4.** Report of Clinical Trials with Nardil in 800 Patients. Warner-Chilcott Department of Clinical Investigation, 1959.

dosage:
Recommended starting dose is one 15 mg. tablet three times a day. After maximum benefit is achieved, usually over a period of several weeks, the dosage is reduced slowly to a maintenance level depending upon individual needs and may be as low as 15 mg. daily.

restores the depressed and despondent patient to reality[1-4]

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Nardil™

are the 2,700,000 people who get some Federal aid as elderly indigents, under a provision of the Social Security Act. Since they're not receiving regular retirement benefits, he says, they wouldn't be eligible for the free hospital and surgical coverage the Forand bill would provide.

Those who would be eligible, argues Moreen, can afford private coverage. In fact, some 40 per cent of them now have it. And he believes insurance companies, by expanding their 65-plus plans, can demonstrate that "this is not an area requiring governmental intervention."

Should a Doctor Expect Free Dental Service?

No matter how a physician feels about professional courtesy, he shouldn't expect free service from his dentist. Dentists can't afford it in these days of high overhead expenses, says Dentist Edward J. Ryan, editor of Oral Hygiene. And he finds free dental service is also bad for the doctor who receives it.

The dentist who treats a medical colleague free "may be carrying generosity to the point of bankruptcy. For every dollar that the dentist collects he pays out about 50 cents to cover his expenses." The recipient knows he's getting something for nothing, so he hesitates to ask for it.

Dentist Ryan's solution: Don't abolish professional courtesy. But extend it in the form of reduced fees for colleagues, not service for free.

For M.D.-Drivers: Here's a Rest From Rock-and-Roll

One way a doctor can make good use of the time spent in his car is to listen to tape-recorded medical readings. But suppose the doctor gets tired of hearing about medicine? A new firm now offers him taped lectures on his choice of cultural subjects.

Academic Recording Institute, Inc. of Houston, Tex., and New York, N.Y., has asked noted scholars to record discussions of American history, political science, philosophy, anthropology, literature, and drama. A subscriber chooses one of these fields, pays $50, and gets one fifty-minute tape a month for ten months on various aspects of it. The purpose of the lectures: "to expose more people to . . . some stimulating ideas."

After all, remarks the firm, a doctor can't get much on his radio these days besides rock-and-roll music. But "if he took along a portable tape recorder and our tapes, he could have a history lesson instead." END



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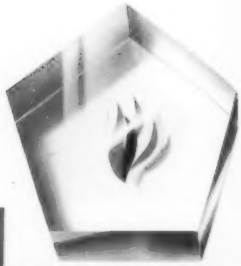
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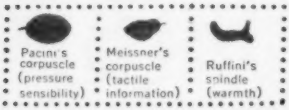
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for example, in discerning the presence and quality of a nodule in the thyroi

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1. Weiner, H. H.: Clin. Med. 5:25 (Jan.) 1958.
2. Giorlando, S. W., and Brandt, M. L.: Am. J. Obst. & Gynec. 76:666 (Sept.) 1958.

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Medical Economics

INDEPENDENT NATIONAL BUSINESS MAGAZINE FOR PHYSICIANS, AUG. 3, 1959



DON'T OVERLOOK CLOSED-END INVESTMENT COMPANIES

Though they're far less popular than the open-end mutual funds, they have some distinct attractions for the physician-investor—such as no loading charge, high potential returns. Here's the full story

By Ralph J. Seymour

What does the term "investment company" mean to you? If you're like most doctor-investors, it means "mutual fund." But that's an oversimplification—and a false one.

The highly publicized mutual funds are only one type of investment company: the so-called *open-end* type. Many financial advisers believe you're missing a good bet if you neglect the *closed-end* type of company. In fact, say some advisers, you'll often find it a better investment than the more popular mutual fund.

How so? To answer the question, let's begin by asking an-

THE AUTHOR *is a Washington, D.C., economist.*

other one: How does the typical closed-end company differ from the typical open-end company?

It doesn't differ at all in its major objectives. Like the mutual fund, it's designed to give you diversification through the purchase of a broad range of securities in one package. And it also provides expert management of your investment money.

Where closed-end companies differ from mutual funds is in their basic financial set-up. The mutual fund is "open" in that it will issue a limitless number of shares. Each new investor simply adds his money to the general pool and gets his shares at a price that directly mirrors the present value of the fund's securities.

But the typical closed-end company issues a fixed amount of stock at the start. Thereafter, if you want in, you must buy

TEN CLOSED-END INVESTMENT

	Distributions in 1958		Share Prices in 1959	
	Ordinary Income	Capital Gains	High	Low
Adams Express Co.	$0.81	$1.25	30½	27¾
American European Securities Co.	0.86	1.94	45	39
Carriers & General Corp.	0.80	0.90	31¾	28
Consolidated Investment Trust	0.57	—	29	17⅝
General American Investors Co.*	0.44	2.20	36⅝	31⅝
General Public Service Corp.	0.15	0.21	5⅞	5⅛
Lehman Corp.	0.53	1.09	31⅞	28⅝
Madison Fund	0.72	0.63	20⅛	18
Tri-Continental Corp.*	1.47	—	42⅝	38⅞
U.S. & Foreign Securities Corp.	0.70	1.44	35	30½

*Has leveraged capitalization. Other companies listed have nonleveraged capitalizations.

your shares from another investor—and sell to another when you want to liquidate. So the price is at least partly determined like that of any common stock: by the law of supply and demand.

Thus, when you buy into a closed-end company, you may pay either more or less for your shares than they're worth in terms of the company's actual holdings. If people are bullish about a given company, its shares may sell at a premium. If investors are inclined to be cautious, the shares may sell at a discount. For example:

As the table at left shows, shares in Adams Express Company—which switched from a freight carrier to a closed-end investment company after World War I—were selling at 10 per cent below their net asset value. At the same time, Lehman Corporation was selling at a premium of 4 per cent.

Does that mean that Lehman Corporation shares are safer or better than Adams Express? Not necessarily.

Often, to be sure, there's a premium on the shares of a company whose management is known to be first-rate. But sometimes an outfit with a highly speculative portfolio will appeal to speculators, who will bid up its price.

COMPANIES

Recent Price	Recent Estimated Asset Value	Recent Discount (d) or Premium (p)
28½	$32.42	10% (d)
40	36.41	11 (p)
29	32.17	10 (d)
21	23.35	13 (d)
33½	36.42	7 (d)
5¼	6.27	10 (d)
29½	29.35	4 (p)
19	21.81	15 (d)
41¼	50.43	20 (d)
32¾	37.56	10 (d)

Don't Look for Discounts

On the other hand, you're not necessarily getting a bargain when you buy a closed-end stock at a discount. You may end up selling it at an even bigger discount—though you may none the less make money on the deal

because of appreciation all along the line.

Why are the closed-end companies so much less popular than the funds? The chief reason may well be psychological:

Inexperienced investors (*most* investors, that is) are apt to distrust the premium-discount aspect of the closed-end issues. It's easy to see why. When you buy a mutual fund, you assume you're paying exactly your proportion of the company's net assets. On the surface, at least, a closed-end stock that you buy at a premium may seem overpriced; at a discount, it may seem—well, maybe too cheap to be good.

But experienced investors go right on buying into the closed-end companies. And with good reason. For one thing, they know that there's a hidden premium or discount built into any stock you buy—in other words, that price always reflects investors' psychology as well as the earning potential of the stock. For another thing, they say that the closed-end companies have the following points in their favor:

1. You don't have to pay a loading charge when you buy them.

Most mutual funds make you pay a commission of around 8 per cent. But you can buy closed-end company shares for regular brokerage fees. Even though you must pay such fees again when you sell your stock, the total cost in commissions is likely to be much less than the one-shot loading charge for a mutual fund.

For instance, a purchase of $2,000 worth of mutual fund shares will cost you $160 if the loading charge is 8 per cent. Brokerage commissions on that amount of closed-end shares will total only $50 ($25 when bought, $25 when sold).

And the more you buy, the wider the spread. You'll pay a $400 loading charge on $5,000 worth of mutual fund shares, for example, as against a total of only $80 on a similar closed-end deal. Only for very large mutual fund purchases—generally $25,000 and up—is the loading rate reduced.

2. Some closed-end companies offer a greater chance for capital gains than do comparable mutual funds.

The reason: Their common stock is "leveraged." This means that the companies issue bonds

or preferred stock in addition to common. To see how leverage can benefit a company's common stock, consider the following example:

The XYZ closed-end company has $50,000,000 in assets, against which it has issued $25,000,000 worth of bonds and a like amount of common stock. As the market rises, XYZ's assets soar to $75,000,000. Since the bonds have a fixed value, it's the common stock that benefits; its value doubles.

That's leverage—something you don't get in the typical open-end company.

It also works in reverse. In a falling market, XYZ's common shares will depreciate faster than those of a comparable mutual fund. But you're investing your money for the long pull, aren't you? And the long pull still appears to be upward.

3. In both bear and bull markets, the shares of closed-end investment companies seem to perform better.

The American Institute for Economic Research recently made a performance study of four open-end and four closed-end issues. The closed-end stocks were of only average quality; the mutual funds chosen for the study were better-than-average performers. Yet the institute found that over a twenty-two-year period (from Dec. 31, 1936, to Dec. 31, 1958), the closed-end issues yielded their investors 42 per cent more than did the mutual funds.

The exact figures for the yield on $1,000 invested in each group are shown below. [*More on 194*]

CLOSED-ENDS VS. MUTUALS: YIELD PER $1,000*

	Closed-Ends	Mutual Funds
Ordinary income (dividends)	$1,590.88	$ 969.06
Capital gains distribution	671.88	708.90
Market value on terminal date	3,840.66	2,617.43
Total return per $1,000 invested	$6,103.42	$4,295.39

*See accompanying text for details.

WHY YOU CAN EXPECT MORE

$150,000 MALPRACTICE VE

A new pattern is developing for placing dollar values on health and human life. It's bad news for doctors. Better get it straight from the judge who set the precedent

By John R. Lindsey

"You're going to see more six-figure verdicts in malpractice trials," Justice Robert Doscher of the Supreme Court of New York told me across the lunch table one day not long ago. About a week earlier, he'd presided at a trial in which the jury had brought in a $150,000 verdict against a surgeon, an anesthesiologist, and their hospital.

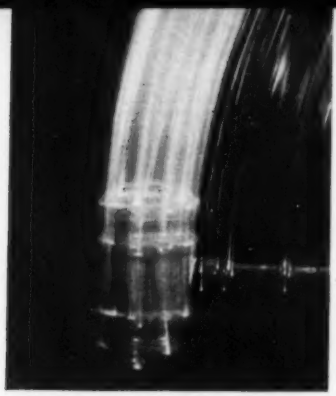
The $150,000 had been awarded to a young man* whose wife had died following surgery, as a result of a blood transfusion in which the wrong type of blood had been used. There have been higher malpractice awards; but this was the biggest ever in the death of a housewife and mother.

"I can give you a good reason why you can expect more such verdicts," the judge added. "A new pattern seems to be developing for placing a value on a human life."

"You mean new ways to set price tags on people?" I asked.

"Price tags? That's too cold-blooded a term for me," Judge Doscher said sharply. "These are real people, remember. They have real claims for justice."

*Technically the award was made to the wife's estate and next of kin.



VERDICTS

"Of course," I said quickly. "But would you mind telling me a bit more about what this new pattern is? And how it's going to affect doctors?"

Justice Doscher poked a fork thoughtfully at a mushroom on his plate. Then he said: "Here's what's new: For the first time—to my knowledge, at least—a New York court allowed expert testimony on the pecuniary value of a housewife's life. And the housewife in this case had neither measurable income nor measurable earning capacity."

"By 'the court,' you mean yourself, don't you?" I asked. The judge nodded.

"But I'm not sure I know what you mean by 'expert testimony on pecuniary value,'" I went on. "I know that doctors qualify as medical experts. But what's a *pecuniary* expert?"

The judge smiled at my question, but he answered it gravely. "That's another term I wouldn't use," he said. "The expert in this case was an expert in the cost of bringing up children who have lost their mother.

"The patient, remember, was 25 years old; and she had two babies, one 4 months old, the other 16 months old. How do you measure the value of such a woman's life?

"I'm not talking about the sentimental value of a woman to her family. There was no testimony on that. This was entirely a dollars-and-cents matter. And the expert witness was a man who has had dollars-and-cents experience in evaluating the phy-

PRICE TAG ON A MOTHER'S LIFE

What's the life of a mother of two infant children worth to her husband? For the first time, in a recent malpractice trial in the Supreme Court of New York, a jury heard expert testimony on this question. Here's how Elliot H. Drisko of the Yonkers (N.Y.) Family Service Society estimated the minimum cost to the husband of replacing the mother of his children, aged 4 months and 16 months:

Wages for substitute mother (combination nurse-governess):	
@ $80 a week for the first 5 years	*$ 20,800*
@ $75 a week for the next 15 years	*58,500*
Wages for part-time housekeeper @ $1.50 an hour 16 hours a week for 20 years	*24,960*
Wages for baby sitter @ $1.00 an hour 6 hours a week (48 weeks a year) for 5 years	*1,440*
Social Security for three employes (substitute mother, housekeeper, and baby sitter)	*4,149.12*
Workmen's Compensation insurance for three employes	*1,500*
Liability insurance	*240*
Advertising for, interviewing, and screening applicants for position of substitute mother	*1,200**
Agency supervision and training of substitute mother	*1,980**
Family counseling and psychological guidance for father	*5,000*
Total for 20-year period	*$119,769.12*

*The average stay of a substitute mother is three years. Careful selection of such a person involves interviewing and screening an average of at least ten applicants every three years or so, according to Drisko. In addition, he said, each successful applicant must be trained and supervised by a child-care agency. Such supervision involves weekly visits to the substitute mother during the first two months, biweekly visits for the next four months, and monthly visits for the following six months.

sical, emotional, and social needs of motherless children."

"As I understand it," I said, "an expert witness can offer opinions based on the facts of the case. But can an expert witness of the kind you're talking about do more than simply estimate the tangible costs to the husband of hiring a housekeeper?"

"Yes, that's the point," replied the judge. "In this case, his testimony went much deeper than that. It went into the question of the cost of 'a substitute mother,' to use the expert's expression. A substitute mother must provide for a child's closest personal needs on a twenty-four-hour basis. And she must provide for them not merely quantitatively, but qualitatively.

'Not Just a Housekeeper'

"So the question before the jury boiled down to this: If the 25-year-old mother of two infants isn't just a plodding housekeeper, but is a highly educated and intelligent woman, how much is her life worth to the family? I felt it was entirely proper to permit the plaintiff's counsel to present expert testimony on this question."

"And you feel your court has set a precedent?" I asked. "Might the same formula apply to another doctor somewhere else, if he's found negligent in similar circumstances?"

It's a 'First'

"I'll put it this way," Justice Doscher replied. "Expert testimony of this kind has never before been admitted in New York's courts. If the case is appealed, a higher court may say it's improper to admit such testimony. And then . . ." He shrugged. "There'd go your precedent, as far as law in this state goes. But the technique of calling expert witnesses of the kind I've been discussing can be copied by plaintiffs' attorneys elsewhere. I'm told it's already been used in one or two other states. So I've no doubt it *will* be copied again."

"And as a result, you anticipate an increase in the size of jury awards against doctors?"

"I think you can put it that way," said Justice Doscher. "But remember that each case has to be decided on its own merits. Given the facts in a case, it's up to the jury to decide first whether there's been negligence, and secondly how much to award in

XUM

PRICE TAG ON A WAGE EARNER'S LIFE

The accompanying article tells how one court recently determined the value of a housewife's life. This was apparently the first time expert testimony had been admitted on the economic worth of a non-wage earner. But for some time now, courts have had a formula for determining compensation in the death of a wage earner or family breadwinner.

The formula isn't fixed by law. It's more a rough rule of thumb. Using it, courts usually figure such compensation as follows:

The jury multiplies the wage earner's annual salary (say, $10,000) by the number of years' life expectancy (say, 40). Of the resultant sum ($400,000) an amount equal to about 60 per cent ($240,000) is likely to be the actual award. Reason: If you gave someone a lump sum equal to 60 per cent of his projected earnings over a lifetime, he'd presumably invest it. Invested at interest, 60 per cent of a man's projected lifetime earnings would eventually match—and at some future point even surpass—his actual lifetime earnings.

compensation for damages. No jury can pull a figure out of the air."

"Suppose it does pull a figure out of the air," I asked. "What can you as presiding justice do?"

In his reply, he once again used the impersonal third person:

"The court reviews the jury's verdict. It can find the award excessive and direct that it be reduced."

"May I ask whether you found this $150,000 award excessive?"

"As a matter of fact," said the judge, "I've just finished my review. We've been talking about a $150,000 verdict. Actually, it was made in two parts: The plaintiff was awarded $130,000 for his wife's death; and he was awarded another $20,000 for her conscious pain and suffering. I've decided to reduce the latter

figure to $5,000, since $20,000 seems excessive to me in this instance, in view of the lack of testimony as to pain and suffering.

"But I'm not setting aside the $130,000 in the death action as excessive. And this is the part of the verdict we've been talking about. It's the part affected by the expert testimony on the value of the patient's life."

For a moment, we lunched in silence. Then I raised a question that had been troubling me right along:

"If this type of testimony has never before been admitted in court, Justice Doscher, why did you allow it in this case?"

"There's nothing in the law to bar such testimony," the judge replied. "It seemed to me an eminently fair way to determine the pecuniary value of a non-wage-earner's life. If you want to see what the child-care expert had to say about it, take a look at the court record."

$120,000 to Rear Them

I'd already examined the record. I'd learned that the child-care expert was Elliot H. Drisko, director of the Yonkers (N.Y.) Family Service Society. He had worked out a twenty-year plan for bringing up the two infants that would cost a minimum of about $120,000. (For details, see page 82.) As Mr. Drisko explained it:

"A substitute mother would have to be a combination of nurse and governess. She'd have to live in the home on a full-time basis and be available on call twenty-four hours a day, to provide the closest personal care and attention which small children require . . . She must have the general education and background to be able to guide and assist them in developing the personal qualities and the social skills necessary for their station in life."

Cost of a Hired 'Mother'

Such a paragon of all-around motherhood would cost a minimum of $80 a week in wages for the first five critical years; $75 a week for the next fifteen. She'd also need help: a part-time woman to do the heavy cleaning and cooking two days a week, plus a baby sitter at least six hours a week during the first five years. And there'd be extra expenses for Social Security, Workmen's Compensation, and liabili-

ty insurance for the substitute mother and her helpers.

What's more, the father himself would need psychological guidance, Elliot Drisko testified. "In my experience," he said, "a father left with the responsibility of small children needs help in interpreting the loss of the mother to the children, assistance in utilizing the substitute mother most effectively and in explaining her to the children . . . For such periodic professional guidance for the father and the children . . . at least $5,000."

That gives you the general idea. I asked Justice Doscher why this type of testimony was 'new" in malpractice cases. "Nobody ever used it before," he answered.

"And if it hadn't been thought of in this case, would the award have been a lot smaller?"

"I can't speculate on anything as hypothetical as that," said the judge. "But if you look up some of the past verdicts in death actions involving housewives, you'll find they're much lower. It has always been much easier to measure the pecuniary injuries to the family when the breadwinner dies."

The significance of what he'd said suddenly struck me: If the life of a house- [*More on 180*]

And bring a mop handle

A young pediatrician I know named Julian Maxwell came home from a house call late one balmy spring afternoon. Several of his young male patients who live on his block were playing stick ball in the street. Dr. Maxwell, having a bad case of spring fever, readily joined in the game when the boys invited him to. He played admirably and felt exhilarated when the game ended.

Two nights later, he was at dinner with his wife when the bell rang. Mrs. Maxwell opened the door to find an 8-year-old urchin standing there in a baseball cap. "Hi," said the young man. "Can Julian come out after dinner and play ball?"

—CYNTHIA SMITH

How Long Should You Keep Patients' Records?

BY CLIFFORD F. TAYLOR

Not long ago, an upstate New York physician wrote MEDICAL ECONOMICS as follows: "My state medical society advises that all records should be kept for six years following the last treatment. The county medical society tells me to keep transient patients' records seven years, all others indefinitely. My lawyer says there's no law compelling me to keep patient-records *any* specific length of time. But he advises me to keep them permanently. What's the score?"

The New Yorker isn't alone in his bewilderment. Caught in the squeeze between ever-bulkier files and limited space, doctors everywhere wonder when it's both ethical and safe for them to throw out their old medical records.

The consensus of medicolegal consultants, medical society officers, malpractice insurance men, and experienced doctors queried recently by MEDICAL ECONOMICS is this:

You're on pretty safe ground if you hold on indefinitely to the records of patients you're likely to treat again—and if you keep all others for at least one year after your state's statute of limitations for malpractice action has run out.*

Remember that if the patient

*The malpractice statute of limitations period for all fifty states and the District of Columbia:

One year:	Calif., Conn., Del., Ky., La., Ohio, Tenn., W. Va.
Two years:	Ala., Alaska, Ariz., Ark., Colo., Ga., Hawaii, Idaho, Ill., Ind., Iowa, Kan., Me., Mass., Mich., Minn., Mo., Neb., N.H., N.J., N.Y., N.D., Okla., Ore., Pa., R.I., S.D., Tex., Va.
Three years:	D.C., Fla., Md., Mont., N.M., N.C., Vt., Wash.
Four years:	Nev., Utah, Wyo.
Six years:	Miss., S.C., Wis.

is a minor, the statute of limitations doesn't begin to operate till he reaches his majority. So you should keep children's records for the recommended period of time *after* they become adults.

Why add an extra year to the statutory time limit? Here's the answer from one malpractice authority:

Margin of Safety

"Suppose you destroy inactive patient-records exactly at the end of the time limit. It's always possible that a former patient will have filed suit against you a few days or weeks earlier, and that you haven't yet been notified. The added year's margin gives you self-protection you'd be foolish not to take."

And a medical society counsel adds: "If you practice in a state where the statute of limitations is only one year, the added year makes you keep all records for two years. And that's the time Federal and state laws say you *must* keep certain records, such as narcotics prescriptions. Also, most physicians feel ethically obliged to make a patient's records available to a successor-doctor for at least a couple of years."

Ethically, it's your duty to retain a former patient's records only as long as he can reasonably be expected to benefit from them. The word "reasonably" is hard to define—which is why there are so many conflicting opinions about how long you should keep your files intact. But most medicolegal men agree that if you refrain from destroying an inactive patient's records long enough to protect *yourself*, you've generally met your obligation to the *patient*.

Exceptions to the Rule

Is there ever a case when it's advisable not to follow the above rule of thumb? Quite possibly. For example, it may be wise to keep certain records indefinitely because of their exceptional medical interest. Or because you feel vaccination dates, certificates of illness, and the like may have a specific value to the patient at some future date.

A Workmen's Compensation claim, for instance, may be reopened over a seven-year period. Your records of such a case might be a big help to the patient long after the statute of limitations has run out.

Remember, too, that even after a patient can no longer sue

you, in most states you can still sue for an unpaid bill. So you might want to keep certain records long enough to help you in collecting. And if suit *has* been brought against you, even if unsuccessfully, you'll want to keep all records on the case until your lawyer is sure there can be no further litigation.

To sum up:

If you can manage it, it's undoubtedly best never to destroy a record while the patient's alive. You may be lucky enough to have the necessary storage space. Or if microfilmed records are legally practical in your state, it's probably worth the expense of having them made.

But if you're like most doctors, you're in the same boat as one harried Wisconsin G.P. with a home-office. His complaint: "My wife says she'll leave me if I can't keep my records from spilling over into the living room."

And you can sympathize with the busy New York City specialist who says: "I've figured out I'm paying $50 a month for record space in my office, plus another $20 a month for old records in dead storage. Something's got to give."

If you also feel that something has to give, you can't go far wrong by following the rule set forth in this article. END

Quick cure

An ENT man met an internist in the hospital elevator one Sunday morning. The internist had his 6-year-old daughter along. As the three left the elevator together, the ENT man said to his colleague in a low voice:

"I couldn't help noticing what adenoidal breathing that child of yours has. As a doctor, don't you think it's time you did something about it?"

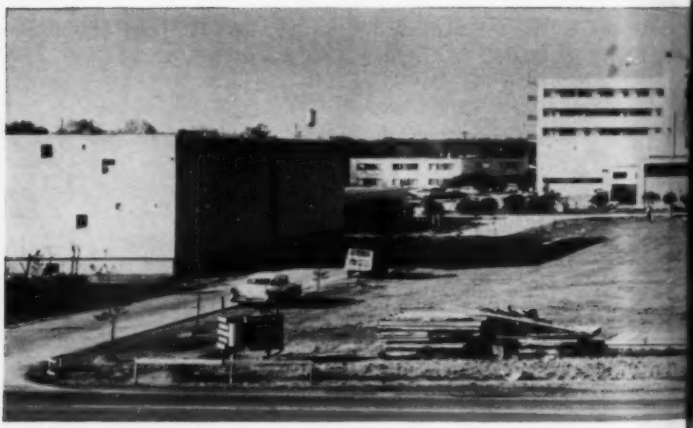
"You're right!" said the internist. "And I'm going to do something right now." He took out a Kleenex and handed it to his daughter. "Sally," he said, "spit out those five packs of bubble gum at once!" —CYNTHIA S. PADER

XUM

INSIDE THE OCHSNER CLINIC

It's called the Mayo of the South. It brings more people into New Orleans than Mardi Gras and the Sugar Bowl. And its doctors believe they've found the best way to practice

BY LOIS R. CHEVALIER



DOCTORS' DREAM COME TRUE: *a view from the top of the levee, showing the twenty-acre "campus" on which the Ochsner doctors have built a new research building, nurses' residence, 250-bed hospital, and a motel for*

If you could have anything you wanted to make your practice more nearly perfect, what would you choose?

Provision for your old age?

Freedom from paper work?

A high percentage of medically interesting cases?

Four weeks' vacation, and twenty days off for medical meetings?

A chance to do clinical research with all necessary technical aids?

A chance to do some teaching —and still work only forty hours a week?

Those are some of the benefits enjoyed by the forty-two partners and thirty-nine staff doctors of the Ochsner Clinic in New Orleans. But the doctors don't get them free. The price they pay is in cold cash.

Says one of the group's most candid physicians: "Every now and then there's a big discussion of money. We all feel we should earn more than we do. To earn more, however, we'd have to curtail our teaching and research activities. We agree this should be done. Then it narrows down to the question: *Whose* teaching



patients' families and convalescents. Half the clinic departments are still housed in the original downtown building, where all patients begin their work-ups. Eventually the entire clinic will be on this site.

XUM

and research should be limited? And there aren't any volunteers. So we go on as before."

When I visited the Ochsner institutions early this summer, I soon understood why the doctors don't want money badly enough to change their way of doing things. For one thing, their financial arrangements seem fair. Every senior partner takes home the same amount. And judging from the comfortable homes the junior partners live in, their shares are at least adequate.

About 65,000 patients a year stream through the Ochsner Clinic. They pay fees that range from $6 to many hundreds. Out of the total take, over $200,000 a year goes into the group's education and research programs. Naturally, that means less money for the doctors. But it also means a lot of professional satisfaction.

Any Ochsner Clinic physician can work with some of the full-time research men on the intriguing borderline between pure research and clinical research; and he can give his patients the benefit of knowledge right at the edge of the unknown. There's a big program of endocrinological research, tied in with cancer, hypertension, and arthritis therapy. There are laboratories devoted to cardiovascular studies, bone pathology, pulmonary physiology, and nuclear medicine, where the work combines investigation and treatment. And there's even work in progress on enzyme chemistry.

Consider, too, the facilities for strictly clinical research: The doctor has access to nearly a quarter of a million medical rec-



DR. ALTON OCHSNER, *founder of the Ochsner Clinic, came from South Dakota to be professor of surgery at Tulane University. He took New Orleans by storm, was one of the few non-natives ever to be a Mardi Gras king. Foundation Hospital is his great love. When he takes visitors through, he even shows them the laundry and kitchens.*

ords, some of which are stored in old houses that have been bought or rented just to provide shelter for the huge collection. These records are filed in such a way that a staff man who wants to review a series of 500 cases of duodenal ulcers in left-handed housewives can have them all on his desk in a few hours.

He can also get movies made of his notable surgical procedures. And he can order slides and every other form of illustrative material for his medical papers and speeches. There's a visual aids department that exists for just such purposes. There's a librarian who will abstract current literature for a doctor who's writing a paper; and there's an editorial department that will prepare his manuscript for publication.



A QUARTER OF A MILLION RECORDS *are stored in cramped quarters like this mezzanine in the old clinic. "We have to hire short girls," says Dr. Guy A. Caldwell, founding partner and medical director.*

In short, medical progress rules the roost at the Ochsner Clinic. I discovered, for example, that there's a resident—or "fellow"—looking over the shoulder of almost every clinic doctor; and the fellows are encouraged to do quite a bit of needling of their chiefs.

In addition to their constant contacts with the fellows, most of the Ochsner doctors teach undergraduate classes. Each man can have half a day off a week for teaching. And 75 per cent of the staff doctors are on the faculties of Tulane or Louisiana State University.

So the clinic is far more than just a medical group. Actually, its research and fellowship training programs aren't strictly clinic activities. They're carried on by the nonprofit Alton Ochsner

XUM

Medical Foundation, a $10,000-000 set-up that's supported by outside gifts in addition to the clinic's contributions. The foundation owns the complex of buildings that house all the Ochsner medical enterprises, including a 250-bed hospital and a brand-new $750,000 research building. Combined payroll for all the Ochsner institutions: $3,000,000 a year.

Sounds like medical Big Business, doesn't it? But it's Big Business with a remarkably personal touch. The Ochsner doctors believe that the psychological well-being of patients—and of patients' families—is a vital part of first-rate patient-care. And the patients respond with an enthusiasm I'd never have believed possible if I hadn't seen it. Hospital patients in particular shower the place with praise. "It's like staying at a resort," one patient said to me. "The food here is as good as Antoine's," commented another, referring to New Orleans' most renowned restaurant.

I was able to turn up only a few complaints—and some of these were funny. For instance, I was told about a former patient who wrote a disconsolate letter

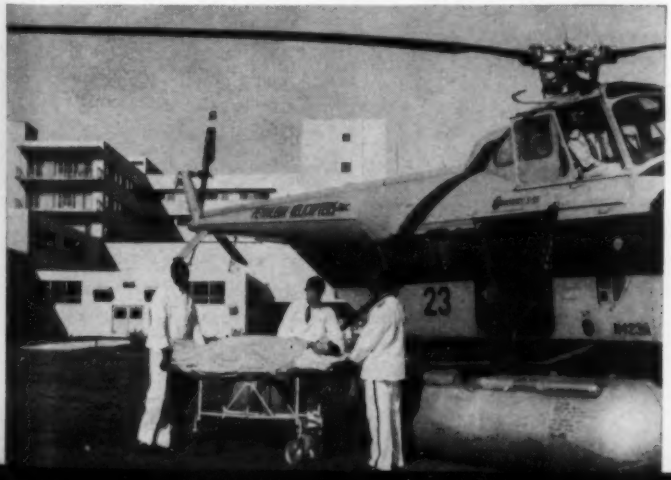
MOTEL ON THE HOSPITAL GROUNDS *serves the families of patients from all over the South and Latin America. A staff of interpreters is on hand to assist Latin Americans. Brent House, as it's called, also provides an economical way-station for ambulatory patients who are not quite well enough to leave their doctors and go home.*





"WE'RE TRAINING OUR SUCCESSORS," *says Dr. Francis LeJeune (center), ENT man who was one of the five founders of the Ochsner Clinic. With him are Dr. William Arrowsmith, one of the younger partners, who sits with the founders on the clinic's board of management, and Dr. Merrill Hines, head of the committee on the acceptance of new doctors.*

SEVERAL LIVES WERE SAVED *by the use of the Ochsner heliport when an off-shore oil rig exploded in the Gulf of Mexico last October. The seriously injured workers were flown 100 miles by helicopter to Foundation Hospital. All had received definitive treatment within five hours after the explosion. The trip by boat and car would have taken ten hours.*



XUM

to the hospital. "Because of someone's negligence," she charged, "I lost a $10 bed jacket and a soft-shelled crab during my stay at your institution."

"The best single thing we've done is to set up a family lounge in our hospital," Dr. Ochsner himself says. The lounge is a special waiting room for the families of patients in surgery. There, a motherly woman serves coffee and comfort—"a nonproductive activity," as Dr. Ochsner terms it. "But money couldn't buy the goodwill it creates," he adds.

The personal touch isn't just a gimmick at the Ochsner institutions. It apparently stems from a truly patient-centered medical philosophy. To illustrate, here's what Alton Ochsner always tells new recruits to the staff:

"Patients' families are sick, too. So as soon as you finish any surgical procedure, be sure you slip on a fresh coat, go to the family lounge, and tell the relatives what you did and how it came out." [*More on 182*]

practice pointer

Sliding-Scale Fees Can Slide Too Far

● How much should the patient's income level influence your fee? Only secondarily, says the A.M.A. Judicial Council. It's ethical to scale your fee up or down "within reasonable limits," in accordance with the patient's ability to pay. But consider doing this only *after* you've considered the "practical value" of the services rendered. This "practical value" is quite different from the theoretical value that might be ascribed to certain life-saving care. Warns the Judicial Council: "Although there are some services which are considered invaluable, none the less their practical value lies within a range—within limits above or below which a fee is unconscionable." END

What to Do About Stock-Market Fever

As certain colleagues can tell you, it starts as a mild itch to speculate. Worse symptoms quickly follow. But here's a doctor-tested antidote

By Horace Cotton

I was sitting in a doctor's office not long ago, sympathizing over a run-in he'd had with his local hospital administrator. Suddenly the doctor said, "Look, I made $4,000 on the stock market last month. Sometimes I wonder why the hell I slave at medicine at all!"

Just a half-humorous remark? Yes—but half-serious too. Since I'd been helping him with his tax returns, I was in a position to answer appropriately:

"Dr. Maddox, I remember that last year you ended up *losing* $8,000 on your stock-market deals. It's nice when you can get money without working for it. But for substantial income and solid growth prospects, you can't beat your medical practice. You'll come out ahead if you concentrate on it."

His real name isn't the one I've

THE AUTHOR *heads the professional management firm of PM Southeast, with headquarters in Southern Pines, N.C.*



used here, but his speculative fever is real. And the same goes for my friend Dr. Semproch. Recently he acted on a tip from a woman patient. He bought a stock she'd heard about, and it promptly went up. In two months he had a paper profit of $800.

Fascinated, Dr. Semproch hung on. By last week, his gain had shrunk to around $500. But the doctor's still telling people he made $800 in two months. And he's searching feverishly for more tips.

Another doctor I know has been bitten harder. Dr. Blauvelt —he's 50—recently cashed in a life insurance policy with a face value of $20,000. He'd had the policy for fourteen years. Why did he turn it in for its cash value alone? Because he'd read in the paper that a stock split was ahead for A.T. & T. He'd decided his family's financial future would be best served if he reduced his insurance coverage in order to raise the cash to buy in.

He bought in, all right, and the stock did split. Dr. Blauvelt now has a tidy paper profit. But if he happens to get hit by a bus while crossing the street one day next week, Mrs. Blauvelt will have to sell the stock fast. She'll have the capital gain, but it won't go anywhere near as far as the insurance would have gone toward putting the three kids through college.

It Takes Time

It's insidious, this itch to speculate. One highly intelligent physician I know keeps insisting that he could make much more out of stocks than he earns in medicine "if I only gave more time to them."

There's the heart of the matter. Playing the market *is* a full-time job. Most of those who do it full-time don't get rich at it. And spare-time speculators have the odds even more against them.

Take the recently publicized story of the Capitol City Investment Club. It was started in 1953 by a group of Eli Lilly employes. They were mostly accountants, statisticians, and engineers—no slouches with a slide rule and a graph. What's more, they worked at their investing. Every month they studied twenty to fifty stocks. They'd buy one, then carefully track its ups and downs, trying to decide when to sell.

After five years, they found all this took far too much time. They

disbanded and sold the whole portfolio. The pay-off? Respectable but hardly mouth-watering, considering five years of time and effort. Each charter member who had kicked in $640 got back $872.

You want to know why I'm playing Cassandra? Why I'm pessimistic at a time when the Dow-Jones average is headed for 700 or maybe 1,000, according to some analysts? Because I've seen too many doctors taking long chances without realizing it —usually in the name of "growth stocks."

Time was when "growth stock" denoted a stock that would inch up steadily as its company carried on research, produced more, sold more, made more profits. Such a company was the infant I.B.M. But look how things have changed:

Today, to many people, "growth stock" means a stock that will shoot up in price *within the next few weeks.* If the stock is already selling at forty times earnings, that doesn't bother them. Will it sell at fifty times earnings three months hence? That's what everybody is peering



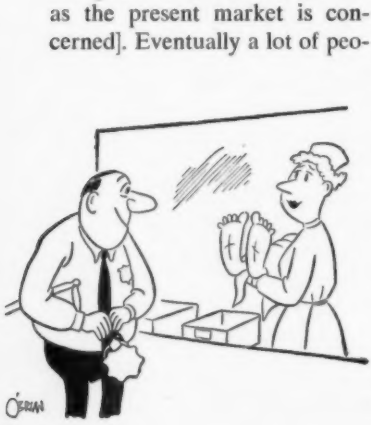
"Really, Doctor, I'm flattered. But I don't think a Wassermann is necessary."

into the crystal ball to guess at.

If all this attention pushes the price of the stock still higher, not enough people ask *why*. All too often, the "growth stock" hasn't grown an inch. It has simply been artificially inflated by people who keep bidding for it in the market. Some day the bubble is bound to burst.

But you needn't take my own gloomy word for it. Listen to a few wise thoughts from the Wall Streeters themselves. Says Heinz H. Biel, respected Forbes magazine commentator:

"Although I have become fairly inured to the wild goings-on in a flourishing bull market, I cannot escape the fear that we are living on borrowed time [as far as the present market is concerned]. Eventually a lot of people will get their fingers burned, or worse."



And don't overlook the go-slow signal from Keith Funston, president of the New York Stock Exchange. Many investors today, says he, "don't realize what they're buying. Some of them probably shouldn't be buying stocks at all."

Does that sort of warning have your name on it, Doctor? Then maybe you'd better do some other things with your money before you join the parade to the stock market.

What other things? Well, here are three thoughts I'm passing on to physician-clients these days:

1. Freedom from debt is a mighty fine investment. If you owe money at interest, figure out what you'll gain by retiring the debt as fast as you can.

Yes, I know all about how you can deduct a debt's interest on your income tax return. Take that into account in your computation. And don't forget to add back the capital gains tax you'd pay if you made the same amount of money on a common-stock deal.

For example, suppose you're in the 50 per cent income tax bracket. By retiring a $10,000

mortgage that has ten years to run at 6 per cent interest, you'll be saving yourself $1,660, even considering the loss of the tax deduction. If you invested the same $10,000 in the stock market, you'd have to make at least $2,213 in capital gains (before taxes) just to equal your mortgage savings. And remember the risk you'd run in the market, on the *chance* of making as much as you make for sure when you pay off your debts.

2. Real estate rolls with inflation's punch, too—just as stocks do, or even better. And real estate isn't so likely as stocks to skyrocket, then crash. Land, bricks, and mortar have been the bedrock of many comfortable fortunes.

Own the place you live in and the place you work in, too, if you can. Then, if the Stock Exchange roof falls in, you'll still have two roofs over your head.

3. Keep your disaster protection up to date. That's life insurance I'm talking about. So it won't pay off in 1959 dollars if you don't die till 1982? Of course it won't. That's a reason to get *more* coverage as the dollar shrinks in value! Since the protective value of the insurance you're now holding has already shrunk through currency inflation, could be that you need more coverage right now.

This means more to lay out in premiums? Well, why not? With inflation, there's more money in your billfold to pay premiums.

And unless inflation backtracks, you'll have more and more dollars to buy more coverage. Think back a few years. Could the physician of 1940 have tackled the premium load you can carry today?

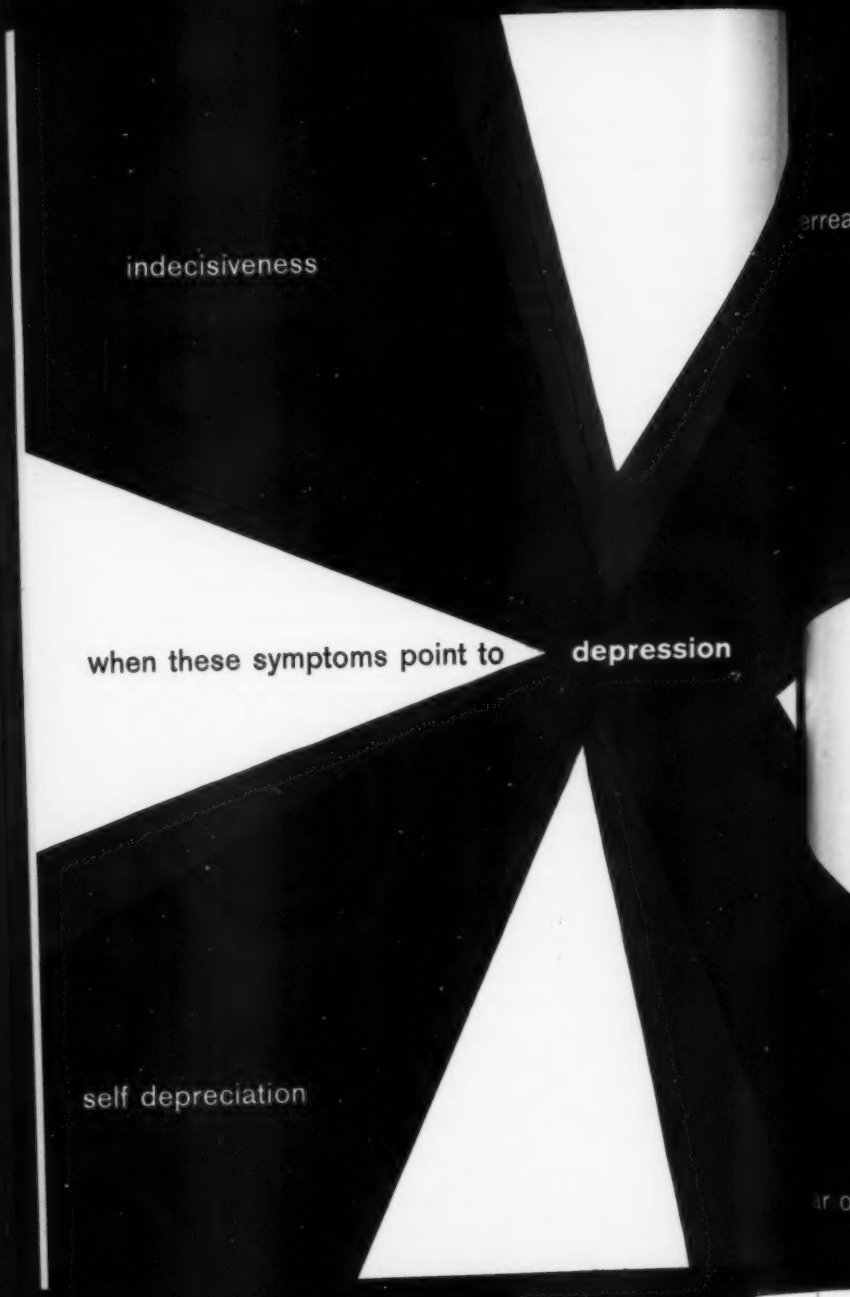
How to Start Right

So much for some stock-market-fever remedies. Maybe you don't need the medicine. If you're out of debt, if you own some real estate, if you have an adequate program of insurance, then by all means go in for a common-stock investment program. But learn a little about investing first. Get your feet wet cautiously.

Try the Monthly Investment Plan if you like. Or try a mutual fund. Or join an investment club if there's one around.

Although investment clubs have a rather high mortality rate (the Lilly men's experience wasn't unique by any means), you'll learn [*More on 196*]

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self depreciation

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Your Daughter's Getting Married?

The happiest day of her life is likely to be the most expensive day of yours. Don't let it catch you unprepared

By Clifford F. Taylor

"The cheapest thing at my daughter's wedding was my formal garb. That's because I rented it for $12.50. A new outfit would have set me back $150."

The doctor—I'll call him Harry Walker—sounded proud as he recalled this stroke of economy. A G.P. in a Long Island (N.Y.) suburban community, he was totaling up the cost of his daughter's wedding a few weeks before. And the rented suit *was* a Spartan note of thrift in a day he figured cost him roughly $3,500.

"That doesn't include things my family tells me we needed anyway—like the new outfit my wife wore to the wedding," he added. "That ran another couple of hundred."

There's no absolute proof that doctors take more of a financial beating when they marry off their daughters than any other fathers do in similar circumstances. But interviews with a good many East Coast doctors and



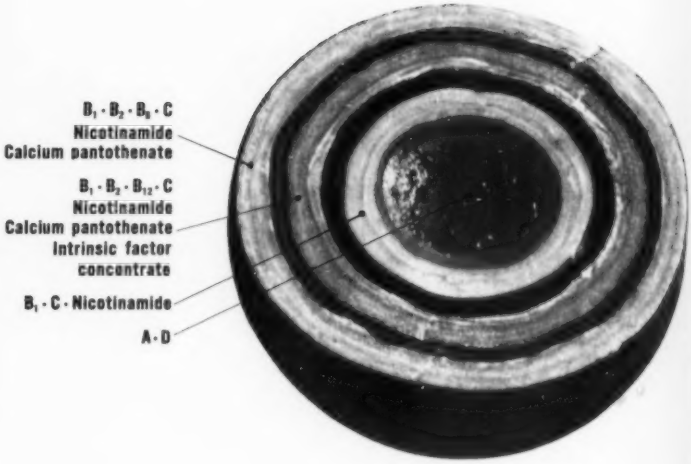
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Nicotinamide . . . . . 50.0 mg.	20.0 mg.	20.0 mg.	10.0 mg.
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Calc. pantothenate . . . . . 10.0 mg.	5.0 mg.	5.0 mg.	
Vitamin C . . . . . 250.0 mg.	100.0 mg.	100.0 mg.	50.0 mg.
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their wives who've been recent parents-of-the-bride point to that conclusion.

"When you've practiced in a town for twenty-five years, you know a lot of people," Dr. Walker points out. "It seems every single one of them will be terribly hurt if they don't get a wedding invitation."

And when they get one, a New Jersey specialist's wife reports, they expect the shindig to be done up brown. "For a church wedding in our community," she says, "you do things the way Emily Post says they should be done. Otherwise, people will say you're scrimping or that you just don't *know*."

Caterers, florists, and various other wedding-day entrepreneurs aren't exactly pushing the cut-rate specials where a doctor's daughter is concerned. Listen to the wife of a New York City surgeon whose daughter recently had a hotel wedding (cost: about $4,500):

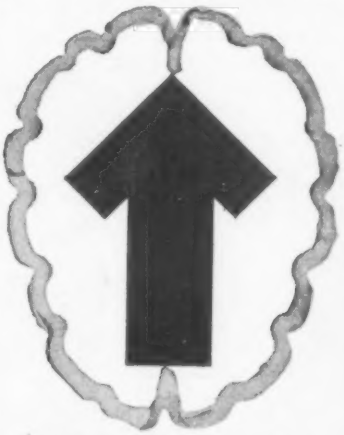
"Caterers and maitre d's think that all doctors are enormously wealthy—that they can and should have the best. They tactfully suggest things should be done in such-and-such a manner. It's awfully hard not to go along with them."

Are these comments and fi-

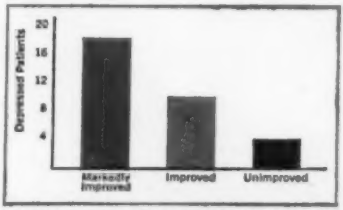
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1. Agin, H. V.: In A Pharmacologic Approach to the Study of the Mind, Springfield, Ill., Charles C Thomas, in press.
2. Agin, H. V.: Conference on Amine Oxidase Inhibitors, New York Academy of Sciences, Nov. 20-22, 1958.

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gures typical? Or do they represent the extravagances of a few Eastern doctors?

The Bride's Magazine recently made a nation-wide survey that answers the question. Church weddings with receptions, it discloses, cost pretty much the same from coast to coast. And there's nothing to indicate that a doctor's daughter's wedding brings less joy to the hearts of caterers and florists in Seattle and Des Moines than it does in New Haven or Brooklyn.

Where exactly does the money go? Or, as Dr. Walker says, "disappear"?

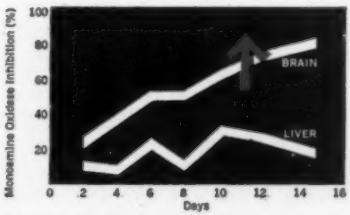
Let's take a closer look at his daughter's wedding. The community is a pleasant suburb, but it's not considered aristocratic. And Dr. Walker says the wedding reception "wasn't nearly as big as I should have thrown." But following are some of the particulars:

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DAUGHTER MARRYING?

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¶ Candid photographs of the church wedding, $150.

¶ Bridal photographs (formal ones for keepsakes and for the newspapers), $100.

¶ Church organist, $35.

¶ Four hired limousines with drivers to take bridal party from church to country club for reception, $60.

¶ Country club reception lasting two and a half hours, $1,500. (The three-piece orchestra was $100. The buffet luncheon was $3 a head for 110 guests. There were expenses for flowers, waiters, parking attendants, etc. "Champagne was the biggest item," comments Dr. Walker. "They drank all they wanted.")

Only the Beginning

This isn't a total itemizing of the wedding cost by any means. "I haven't got all the bad news yet," explained Dr. Walker. So for some of the niceties he neglected to mention, let's go back to the New Jersey nuptials blueprinted by Emily Post:

¶ Wedding announcements, $180.

¶ Wedding invitations, $150.

¶ Flowers for church, $175.

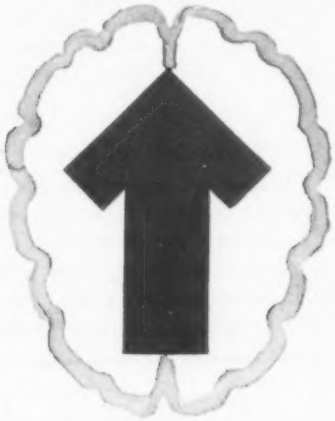
¶ Gifts for bride's attendants, $75.

More▶

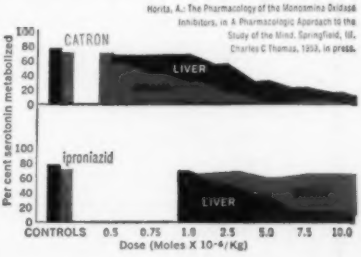
new psychoactive agent

Catron

β-phenylisopropyl hydrazine supplied as the hydrochloride



Elevates mood, brightens outlook by raising levels of mood-controlling neurohormones, serotonin and norepinephrine . . . at doses which have little or no effect on the liver.



Horita, A.: The Pharmacology of the Monoamine Oxidase Inhibitors, in A Pharmacologic Approach to the Study of the Mind. Springfield, Ill., Charles C Thomas, 1959, in press.

Lakeside Laboratories, Inc. Milwaukee 1, Wisconsin

84559-C

And so on. What's more, the wedding itself doesn't account for nearly all the expense. According to etiquette, the bride's family is also expected to furnish linens and clothes for the bride's first year of marriage. As well as a wedding gift "of substance," usually silver.

It's Never Too Early

Maybe it's much too early for your daughter to be thinking of marriage. But on the basis of present-day wedding costs and the experiences of father-of-the-bride physicians, she can hardly be too young for *you* to start thinking about it. And planning for it. Because a bride's father is expected to absorb just about the entire cost of the wedding and almost everything else that might be even remotely connected with it.

Well, not *quite* everything. The groom always pays for the wedding ring, the marriage license, and his own and his ushers' boutonnieres.

Always? "Don't bank on it," says one doctor. "Not if she does what my daughter did. She married a first-year interne." END



Have you changed your address?

To insure uninterrupted delivery of your copies of MEDICAL ECONOMICS, please fill out and return the coupon below:

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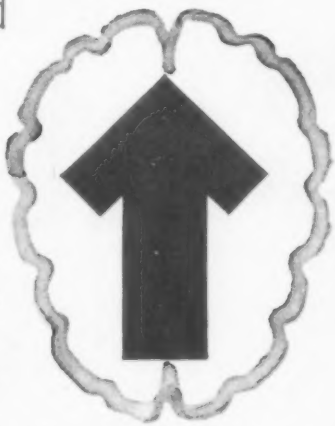
New address:

STREET _____

CITY _____ ZONE _____ STATE _____

8359

withdrawn **apathetic** rejected **gloomy**
remorseful hopeless **listless** despairing
forlorn **somber** defeated
bitter crushed



WHEN THE WORDS MEAN DEPRESSION, THE TREATMENT IS

Catron

β-phenylisopropyl hydrazine supplied as the hydrochloride

Important new psychoactive agent—acts selectively on the brain to brighten outlook, raise spirits, rebuild self-esteem, revitalize depressed patients.

Lakeside Laboratories, Inc., Milwaukee 1, Wisconsin

8659-D

For detailed information, request Brochure No. 19, CATRON

Important New

Catron®

β-phenylisopropyl hydrazine supplied as the hydrochloride



Lakeside Laboratories, Inc., Milwaukee 1, Wisconsin

How to use this new drug:

CATRON Hydrochloride is a monoamine oxidase (MAO) inhibitor useful in the treatment of depression and of other disorders indicated below. It is recommended for use in carefully selected cases and in those patients who have not responded to the milder drugs.

ADMINISTRATION AND DOSAGE

Dosage of CATRON must be individualized according to each patient's response. The initial daily dose should not exceed 12 mg. and should be reduced as soon as the desired clinical effect is obtained. In severe depressions some clinicians desire rapid results and begin treatment with 24 mg. daily: this dosage should not be continued for more than a few days. A single daily dose in the morning is recommended. A continuous or interrupted schedule may be used, the latter during the maintenance period.

DEPRESSION (Endogenous, Reactive, Postpartum, Involutional and Depression Secondary to Schizophrenic or Neurotic Reaction): initially, 12 mg. once daily for approximately 2 weeks, or less if improvement appears. Dosage is then reduced to 6 mg. daily. As improvement continues, maintenance dosage of 6 mg. every other day or of 3 mg. daily often proves satisfactory. An interrupted dose schedule is recommended for long-term therapy.

ANGINA PECTORIS—3 to 6 mg. daily in most cases. Relief of pain and elevation of mood may be dramatic. Victims of angina pectoris who respond in this manner should be cautioned against overexertion induced by their sense of well-being.

RHEUMATOID ARTHRITIS (Adjunctive Therapy—in severely disabling forms, particularly when accompanied by depression): 9 to 12 mg. daily for 3 days, then 6 mg. daily, reducing further to 3 mg. daily on signs of improvement. If a conventional antiarthritic agent is used, lower doses of each are indicated.

CAUTION

Certain circumstances should be watched carefully when using CATRON.

DRUG POTENTIATION—The list of drugs which CATRON potentiates is not yet complete. CATRON should not be used concomitantly with any other drug unless, (a) it has been ascertained that the two drugs bear no qualitative relationship, or (b) potentiating action is being sought, as may be the case with tranquilizing drugs including reserpine and the phenothiazines, and with the amphetamines, barbiturates and hypotensive agents.

HYPOTENSIVE EFFECT—All normotensive patients receiving CATRON, but especially elderly patients, should be warned about the possibility of orthostatic hypotension during the initial period of higher dosage. In the few instances where this may occur, lowering of the dose will usually permit continuation of therapy.

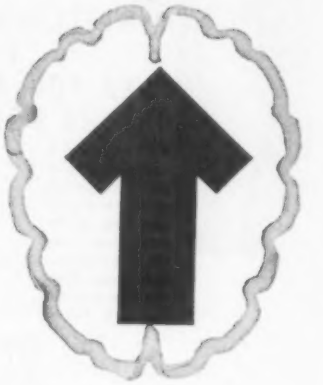
COLOR VISION—A reversible red-green color defect has been reported in a few patients, chiefly hypertensives, on ex-

ew Psychoactive Agent

ghtens mood, diminishes apathy and confusion, curbs
toms of withdrawal, self-pity, inadequacy, despair.[1,2]

s selectively on brain at doses having little
effect on liver.[3-7]

able in depressions associated with
c diseases such as angina pectoris,[8] severe
matoid arthritis.[9]



ted information, request Brochure No. 19, CATRON

1, Wisconsin

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ic therapy with CATRON. Discontinue the drug if such
ms occur.

AL, NEUROLOGIC SIGNS—In toxicity studies with animals,
urologic syndrome has been observed characterized
emors, muscle rigidity and difficulty in locomotion.
ugh extensive clinical experience has not shown such
ons to be a problem in humans in recommended
e, should a similar neurologic disturbance occur, the
ibility of drug action should be considered.

EFFECTS—Major side effects requiring cessation of
py are infrequent. Other side effects—constipation,
y in starting micturition, increased sweating, hyper-
ia, ankle edema, blurring of vision, dryness of the
h—are usually readily controlled by lowering the dos-
Flush, observed in a few patients, cleared up rapidly
discontinuing therapy.

ION: Pharmacologic studies show that with proper dos-
CATRON will inhibit monoamine oxidase in the brain
ut influencing this enzyme in the liver. This is in
ast to previous inhibitors, which depress monoamine
e activity in the liver before affecting this enzyme
brain.

ugh the evidence suggests that serious life-threaten-
epatitis seen with other MAO inhibitors should not
with CATRON in the recommended dosage, it has
reported on rare occasion with dosages in excess of
commended levels.

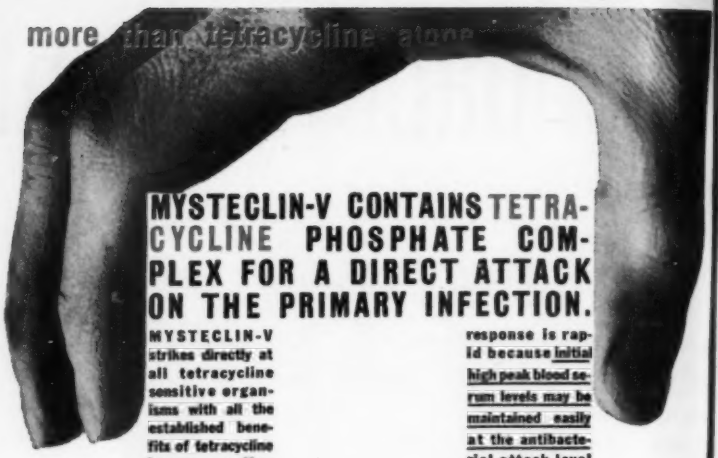
llowing Precautions are Recommended:

1. In all instances daily dose should not exceed 12 mg.
2. Reduce daily dose as soon as response is established, usually in a matter of 1 to 2 weeks.
3. Do not prescribe to a patient more than sixteen 6 mg. tablets or thirty-two 3 mg. tablets of CATRON at one time.
4. Patient should return for observation before additional CATRON is prescribed. For this reason, prescriptions for CATRON should be marked, "not refillable."
5. Perform regular liver function tests.
6. Do not use the drug in patients with a history of viral hepatitis or other liver abnormalities.

CATRON is the original brand of β-phenylisopropyl hydrazine. It is supplied as the hydrochloride in tablets of 3 mg. and 6 mg., bottles of 50.

(1) Agin, H. V.: The Use of JB-516 (CATRON) in Psychiatry, Conference on Amine Oxidase Inhibitors, New York Academy of Sciences, Nov. 20-22, 1958. (2) Bercel, N. A.: A Pharmacologic Approach to the Study of the Mind, Springfield, Ill., Charles C Thomas, 1959, in press. (3) Kinross-Wright, J.: Panel Discussion of Psychic Energizers, *ibid.* (4) Kinross-Wright, J.: Experience with JB-516 (CATRON) and Other Psychochemicals in Clinical Practice, Conference on Amine Oxidase Inhibitors, New York Academy of Sciences, Nov. 20-22, 1958. (5) Horita, A., and Parker, R. G.: Comparison of Monoamine Oxidase Inhibitory Effects of Iproniazid and Its Phenyl Congener, Proc. Soc. Exper. Biol. & Med. 99:617, 1958. (6) Horita, A.: Beta-Phenylisopropylhydrazine, A Monoamine Oxidase Inhibitor, Fed. Proc. 17:379, 1958. (7) Horita, A.: The Pharmacology of the Monoamine Oxidase Inhibitors, in A Pharmacologic Approach to the Study of the Mind, Springfield, Ill., Charles C Thomas, 1959, in press. (8) Kennamer, R., and Prinzmetal, M.: Treatment of Angina Pectoris with CATRON (JB-516), Am. J. Cardiol. 3:542, 1959. (9) Scherbel, A. L., and Harrison, J. W.: The Effects of Iproniazid and Some Other Amine Oxidase Inhibitors in Rheumatoid Arthritis, Conference on Amine Oxidase Inhibitors, New York Academy of Sciences, Nov. 20-22, 1958.

XUM



MYSTECLIN-V CONTAINS TETRACYCLINE PHOSPHATE COMPLEX FOR A DIRECT ATTACK ON THE PRIMARY INFECTION.

MYSTECLIN-V strikes directly at all tetracycline sensitive organisms with all the established benefits of tetracycline in new, more effective phosphate complex form.[1] Patient response is rapid because initial high peak blood serum levels may be maintained easily at the antibacterial attack level until the infection is conquered.

MYSTECLIN-V CONTAINS MYCOSTATIN FOR SPECIFIC DEFENSE AGAINST SECONDARY MONILIAL SUPERINFECTION.

MYSTECLIN-V protects your patient against antibiotic induced intestinal moniliasis and its complications, including vaginal and anogenital moniliasis, even potentially fatal systemic moniliasis. This protection is provided by Mycostatin, the antifungal antibiotic, with specific action against Candida (Monilia) albicans.[2]

BOTH ARE OFTEN NEEDED WHEN BACTERIAL INFECTION OCCURS

MYSTECLIN-V

Squibb Tetracycline Phosphate Complex (Sumycin) and Nystatin (Mycostatin)

CAPSULES (250 mg./250,000 u), bottles of 16 and 100. HALF-STRENGTH CAPSULES (125 mg./125,000 u), bottles of 16 and 100. SUSPENSION (125 mg./125,000 u per 5 cc.), 2 oz. bottles. PEDIATRIC DROPS (100 mg./100,000 u per cc.), 10 cc. dropper bottles.

REFERENCES: 1. Cronk, G. A.; Naumann, D. E., and Casson, K.: Antibiotics Annual 1957-1958, New York, Medical Encyclopedia Inc., 1958, p. 397. • 2. Newcomer, V. D.; Wright, E. T., and Sternberg, T. H.; Antibiotics Annual 1954-1955, New York, Medical Encyclopedia Inc., 1955, p. 686.

'MYSTECLIN'®, 'SUMYCIN'® AND 'MYCOSTATIN'® ARE SQUIBB TRADEMARKS

SQUIBB

Squibb Quality—the Priceless Ingredient

They sell your patients . . .

'Good Health at $19.50 a Box'



By Lois R. Chevalier

As a doctor, you hear many complaints about the cost of medical care and drugs. It isn't always easy for you to persuade your patients of the need for such expenses.

Want to know how some very different purveyors of health do an even harder "selling job" with ease? They're the people who sell a food supplement that costs $19.50 a box. One box lasts a month. And in this best-nourished of countries, some $20,000,000 worth of the boxes were sold last year.

An American Druggist magazine survey indicates that all the preventive vitamin prescriptions written by U.S. doctors in 1958 amounted to little more than $29,000,000. Did any of your patients grumble about the cost of your Rx? They may be the same people who gladly paid out $19.50 a month for a plastic box of tablets and capsules labeled "Nutrilite."

And they didn't buy it in a drugstore. They bought it from a door-to-door salesman.

The A.M.A., the U.S. Food and Drug Administration, and the Better Business Bureau are all concerned about possible misrepresentation by door-to-door vitamin salesmen. Some of your A.M.A. dues money is going into a public education campaign against what the association considers food faddism. But in spite of this general climate of disap-

There is A Therapeutic Reason for The Decorative Jar

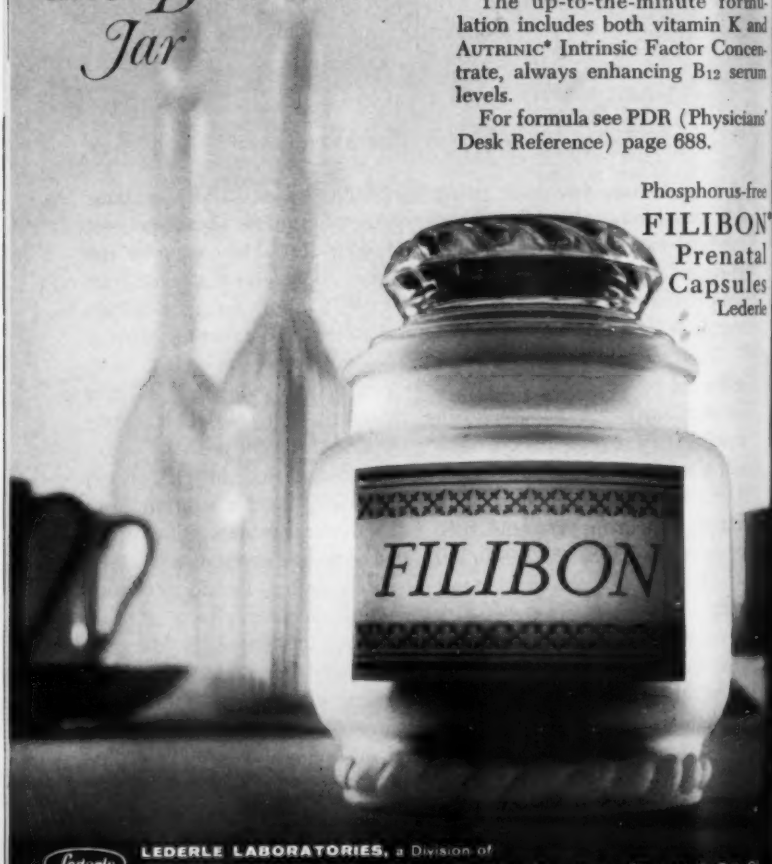
The attractive FILIBON jar reminds your pregnant patient to take her prenatal supplement daily. You can be sure that the vitamins, minerals, trace elements in this complete formula will provide the *everyday* nutritional support you prescribed.

And the patient feels better on FILIBON. Well tolerated ferrous fumarate and smaller, dry-filled capsules do not compound her problems with nausea of pregnancy.

The up-to-the-minute formulation includes both vitamin K and AUTRINIC* Intrinsic Factor Concentrate, always enhancing B_{12} serum levels.

For formula see PDR (Physicians' Desk Reference) page 688.

Phosphorus-free
FILIBON*
Prenatal
Capsules
Lederle



Lederle LEDERLE LABORATORIES, a Division of AMERICAN CYANAMID COMPANY, Pearl River, New York *Reg. U. S. Pat. O

proval, the "friendly Nutrilite Distributor," as he's termed in a company brochure, continues to flourish.

Why? There are two basic answers:

1. Americans are notoriously health-minded. Nutrilite concentrate is made partly from alfalfa, watercress, and parsley, which spring from health-giving Mother Earth. And the Nutrilite salesman is trained to show a warm, healthy interest in his customer's well-being.

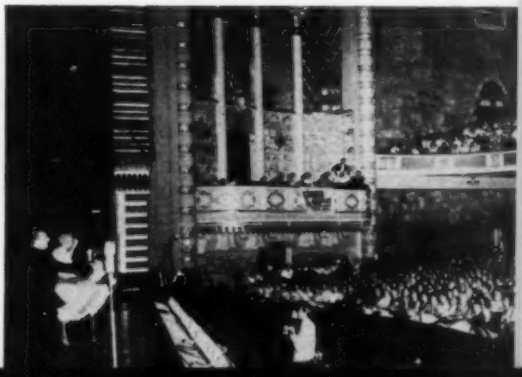
2. Americans like to make money. Some of them can make scads of it by selling Nutrilite.

Do you think of door-to-door selling as the last resort of the chronically unemployed? If so, you're wrong. A few of the Nutrilite salesmen are making far more money than the average physician does. They subscribe heartily to the philosophy of the company's sales division—a philosophy that has been expressed in the following terms:

"If someone pointed to a button and said, 'You may press this button as often as you like. Each time you press it, I'll give you $2,' what would be your reaction? Would you press it very often? Fortunately, there is such a button . . . It's called a doorbell."

That's the kind of pep talk that invigorates the 50,000 men and women who sell Nutrilite, the giant of the food-supplement field. They sell on a fantastic incentive plan that works almost like a chain letter. Each agent collects a commission on the sales of the other salesmen whom he has recruited. The earnings of a top agent can pyramid into over $50,000 a year.

But the game has its hazards: The Nutrilite salesman risks a tangle with the F.D.A. if he tries



NUTRILITE SALESMEN, *who are known as "distributors," gather by the thousands for a razzle-dazzle sales meeting, including exhortations, cheers, and group singing. Some observers say that on occasion their enthusiasm approaches mass hysteria.*

because many diseases involve emotional and physical stress...

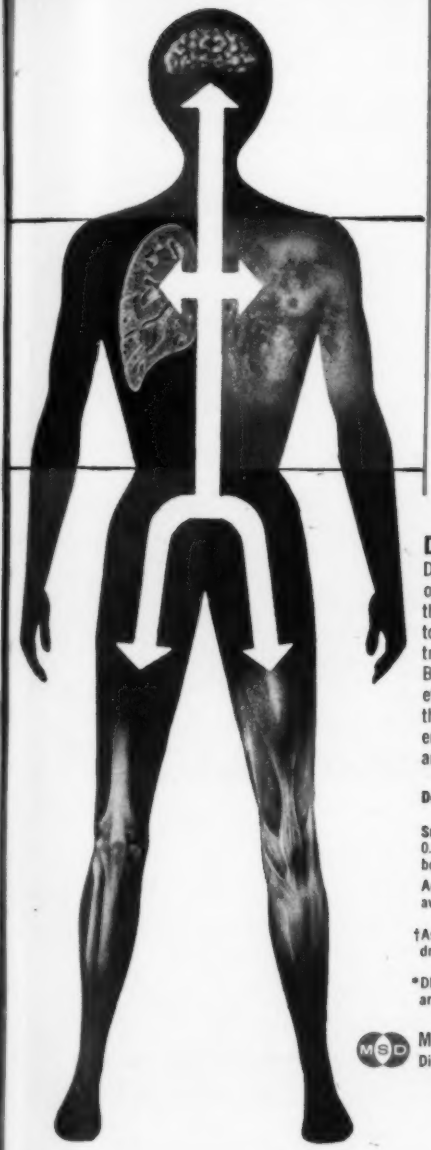
in asthmatic and other allergic conditions†

NEW

DECABAMATE*

DECADRON® with Meprobamate

treats more of the patient more effectively





DECABAMATE links the action of DECADRON®, the most potent and effective of the antiallergic steroids, with the most widely accepted and well tolerated of the muscle-relaxant tranquilizers, meprobamate . . . By treating more of the patient more effectively, DECABAMATE can often make the difference between disability and employability in many asthmatic and other allergic conditions.

Dosage Range: One or two tablets t.i.d. or q.i.d.

Supplied: As scored yellow tablets providing 0.25 mg. DECADRON plus 200 mg. meprobamate; bottles of 100.

Additional information on DECABAMATE is available to the physician on request.

†Asthma, allergic rhinitis, serum sickness, drug sensitivity, and laryngeal edema.

*DECABAMATE and DECADRON are trademarks of Merck & Co., Inc.

MSD MERCK SHARP & DOHME
Division of Merck & Co., Inc., Philadelphia 1, Pa.

XUM

to compete with you as a healer. Not long ago, the F.D.A. gathered evidence that one such man was claiming his product would help sufferers from arthritis, migraine headache, and Buerger's disease. He pleaded guilty and paid a fine. Other salesmen in Ohio, New York, and Washington, D.C., have been successfully prosecuted for making fraudulent claims.

The home office in Southern California makes no effort to rescue such men. "We're totally in favor of what the F.D.A. stands for," says Carl Rehnborg, founder of Nutrilite Products, Inc. "The distributors are forbidden to make claims. We don't want them to be amateur doctors. They're supposed to be grocery salesmen."

The groceries that your pa-

THE MAN BEHIND A $20,000,000 BUSINESS





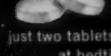
Carl Rehnborg, self-educated chemist, made and lost a fortune in the export business in China before he developed his secret process for refining alfalfa and similar vegetation. This Nutrilite business will eventually belong to the employes. Rehnborg himself has transferred a lot of his attention to other projects: his hotel chain in the South Sea Islands; his new process for extracting coconut oil that he hopes will bring prosperity to Tahiti.

But he still jumps into his Mercedes-Benz every now and then for a run out to the Nutrilite farms in Hemet, Calif., where hundreds of acres of pampered alfalfa and parsley are grown.

Established Standard Therapy in Hypertension*

Rauwiloid®

alseroxylon, 2 mg.



just two tablets at bedtime

After full effect one tablet suffices

*Because

Rauwiloid provides effective Rauwolfia action virtually free from side effects...the smooth therapeutic efficacy of Rauwiloid is associated with significantly less toxicity than reserpine...and with a lower incidence of depression. Tolerance does not develop.

Rauwiloid is initial therapy for every hypertensive patient. ...Dosage adjustment is never a problem...

•

When more potent drugs are needed, prescribe one of the *convenient single-tablet combinations*

Rauwiloid® Veriloid

alseroxylon 1 mg. and alkavervir 3 mg.

or

Rauwiloid® Hexamethonium

alseroxylon 1 mg. and hexamethonium chloride dihydrate 250 mg.

Many patients with severe hypertension can be maintained on Rauwiloid alone after desired blood pressure levels are reached with combination medication.

Riker

Northridge, California

XUM

ROCHE LABORATORIES IS PRIVILEGED TO ANNOUNCE A NEW DEVELOPMENT TO STOP AS WELL AS PREVENT VOMITING AND NAUSEA

Tigan

The first specific antiemetic/antinauseant entity

NOT A CONVERTED ANTIHISTAMINE • NOT A CONVERTED TRANQUILIZER • NOT A CONVERTED SEDATIVE • NOT A COMBINATION



1

Chemically
different as well as new—
a specific antiemetic entity.[1]

2

Pharmacologically
different as well as new—
no demonstrable effects other than antiemesis.[2]

3

Therapeutically
different as well as new—
stops *active* vomiting in addition to prophylactically preventing nausea and emesis.[1,3-5]

4

Clinically
different as well as new—
effective against vomiting and nausea in the widest range of common and special situations, such as pregnancy, travel sickness, gastrointestinal disorders, uremia, carcinomatosis, drug poisoning, radiation sickness, postoperative states.[1,3,4-6]

5

Practically
different as well as new—
patients may drive, fly and work in hazardous situations, even when previously interdicted with other agents.[1,2,4-6]

Controlled clinical investigations encompassing 3,000 patients have been completed to date.

No special precautions—
No known contraindications

Tigan affords such antiemetic efficacy, safety and pharmacologic precision that virtually all of the special precautions that have complicated older therapies are obviated. The singular absence of side effects makes it possible to use Tigan even in the presence of common contraindications of older antiemetics.[1-9]

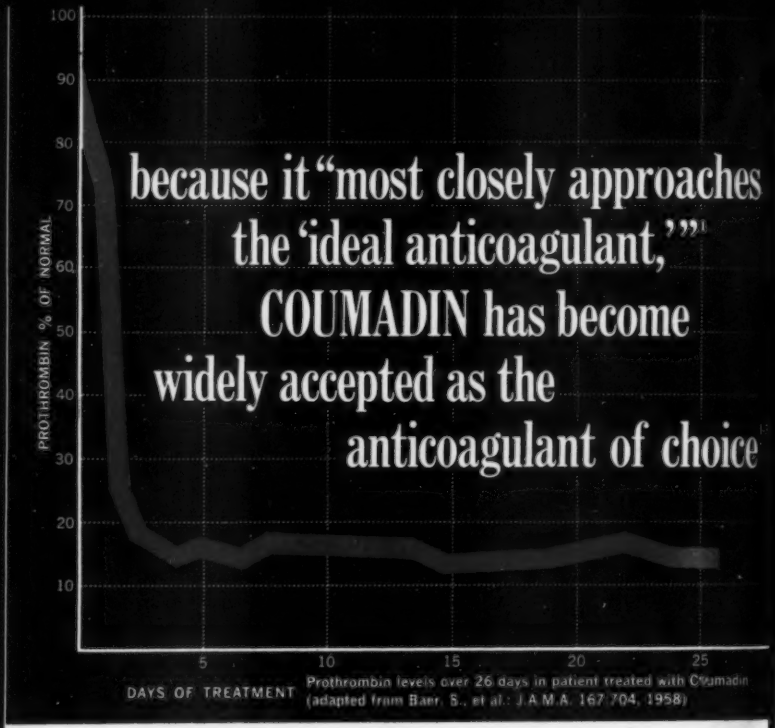
Dosage: **The recommended adult dosage is one or two capsules four times a day.**

Available: **Capsules—100 mg, blue-and-white, bottles of 100 and 500.**

References: 1. Reports on file, Roche Laboratories. 2. W. Schallek, G. A. Heise, E. F. Keith and R. E. Bagdon, *J. Pharmacol. & Exper. Therap.*, in press. 3. I. Rosoff, W. B. Abrams, J. Kaufman, L. Goldman and A. Bernstein, *J. Newark Beth Israel Hosp.*, 9:189, 1958. 4. W. B. Abrams, to be published. 5. O. Brandman, to be published. 6. Personal communications. 7. P. K. Conner, Jr., S. Kinard, W. Fraser, H. Bennett and J. H Moyer, Scientific Exhibit, A.M.A. Clinical Meeting, Seattle, Nov. 27-30, 1956. 8. *New and Nonofficial Drugs*, Philadelphia, J. B. Lippincott Co., 1959, p. 362. 9. J. H. Moyer, in *Drugs of Choice 1958-1959*, St. Louis, The C. V. Mosby Co., 1958, p. 336.

TIGAN® —brand of trimethobenzamide ROCHE®

ROCHE LABORATORIES
Division of Hoffmann-La Roche Inc.
Nutley 10, N. J.



COUMADIN®

SODIUM

ORAL
I.V. or I.M.

IN MYOCARDIAL INFARCTION AND OTHER THROMBOEMBOLIC DISORDERS

According to Link,[2] discoverer of Dicumarol®:

"most of the drawbacks of Dicumarol have been overcome [with COUMADIN]... It is my firm belief that in time it will replace Dicumarol on the basis of its performance over a wide variety of conditions..."

After more than five years' clinical experience, it has been concluded:

"In my opinion, Warfarin sodium [COUMADIN] is the best anticoagulant available today."[3]

COUMADIN CONSISTENTLY PROVIDES

rapid and sustained effect with low dosage • high predictability • ease of control for long periods • low incidence of "escape" • equal effectiveness by oral or parenteral routes • reduced need for frequent prothrombin time determinations after initial dosage adjustment • ready reversibility with vitamin K_1

TABLETS—*for oral administration*—2 mg., lavender, scored; 5 mg., peach, scored; 10 mg., white, scored; 25 mg., red, scored.

INJECTION—*for parenteral administration*—Single Injection Units, consisting of one vial, 75 mg., and one 3-cc. ampul Water for Injection.

AVERAGE DOSE—*initial*, 50 mg. *maintenance*, 5-10 mg. daily, as indicated by prothrombin time determinations.

COUMADIN (warfarin) Sodium—manufactured under license from the Wisconsin Alumni Research Foundation—*developed for clinical use by Endo.*

References: 1. Baer, S., et al.: J.A.M.A. 167:704, 1958. 2. Link, K. P.: Circulation 19:97, 1959. 3. Meyer, O. O.: Postgrad. Med. 24:116, 1958.

Complete Information and Reprints on Request

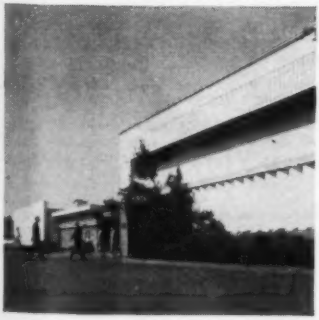
Endo® ENDO LABORATORIES
Richmond Hill 18, New York

XUM

tients buy in a Nutrilite box consist of crystalline vitamins and minerals, like those put out by any ethical drug house, plus a green substance called Nutrilite Concentrate. This concentrate consists of alfalfa, parsley, watercress, and yeast. Carl Rehnborg and his wife started making it by hand some thirty years ago.

"That was about the time they'd just begun to make vitamins in crystalline form," says Rehnborg, a vibrantly healthy man of advanced years. Some boosters think the concentrate contains important nutritional factors not yet isolated. *More*▶





PEDIATRICIAN'S DREAM: *the family of Bob and Frances Fields, the nation's top Nutrilite salesmen, all obviously chock-full of vitamins.*

BLOCK-LONG HEADQUARTERS *of Nutrilite Products, Inc., in Buena Park, Calif., where the nation's best-selling food supplement is made. The company owns another building where it has a $300,000 research program in progress.*

Fostex® treats their acne while they wash



degreases the skin helps remove blackheads dries and peels the skin

...and this is how it works

Fostex provides the essential actions necessary in treating acne. It washes off excess oil. It unblocks pores by penetrating and softening blackheads. It dries and peels the skin, removing papule coverings, thus permitting drainage of sebaceous glands.

Fostex contains Sebulytic®,* a combination of surface-active wetting agents with remarkable antiseborrheic, keratolytic and antibacterial actions... enhanced by sulfur 2%, salicylic acid 2%, hexachlorophene 1%.

*sodium lauryl sulfoacetate, sodium alkyl aryl polyether sulfonate and sodium dioctyl sulfosuccinate.

Your patients will like Fostex because it is so simple to use. They simply wash acne skin 2 to 4 times a day with Fostex, instead of using soap.

FOSTEX CREAM

... in 4.5 oz. jars. For therapeutic washing in the initial phase of oily acne treatment.

FOSTEX CAKE

... in bar form. For therapeutic washing to keep the skin dry and free of blackheads during maintenance therapy. Also used in relatively less oily acne.

Write for samples.

WESTWOOD PHARMACEUTICALS Buffalo 13, New York

XUM



SPECTOGRAPHIC ANALYSIS *assures the uniformity and quality of Nutrilite, say its manufacturers, even though they won't reveal its secret formula.*

"But," Mr. Rehnborg says, "we don't make any claims."

Back in the early days, when the business was a-building, the Nutrilite sales division was less scrupulous. The product was sometimes described as an effective therapeutic agent in low blood pressure, ulcers, pyorrhea, tonsillitis, hay fever, headache, boils, nosebleed, asthma, high blood pressure, sinus trouble, eczema, colitis, and deafness. Under the terms of a Federal Court injunction obtained by the F.D.A., the sales literature has been extensively revised.

Today "distributors" get a manual that helps them counter every possible form of sales resistance—without naming a single disease. With the approval of the company's attorneys, they can quote portions of Government publications on nutrition in general and on the importance of specific vitamins. So instead of promising a cure for sickness, the cautious salesman simply tries to convince prospects of their need to be well nourished.

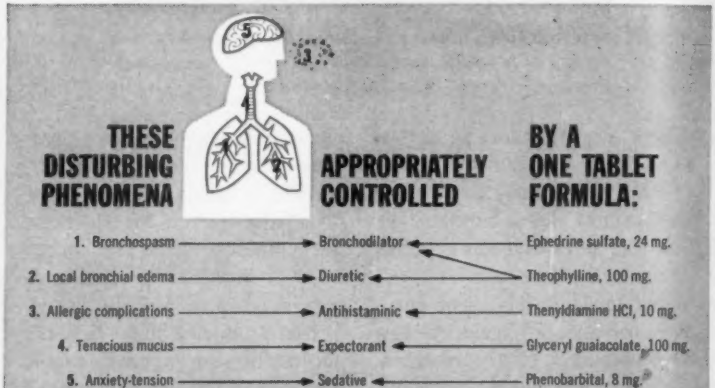
Many a doctor might envy the success of such a commendable campaign. Even though a month's supply of Nutrilite for one person costs $19.50, the product sells like—well, like Nutrilite. "I buy good health at only $19.50 a box," says one satisfied customer. And a high proportion of the people who buy it turn around and start selling it. (Maybe that's the only way they can afford the required amount.)

"The friends we've made through Nutrilite—both customers and sales associates—number more than we had ever hoped

NEW AND EXCLUSIVE . . . the only 5-action, one-tablet treatment . . . for comprehensive control of your asthma patients, prescribe

BRONKOTABS®

TRADEMARK



CLINICALLY PROVEN—good to excellent results in 91% of 593 patients.[1]

WELL TOLERATED—side effects in these studies mild and temporary—incidence only 4.7%.[1]

INDICATIONS—For prevention or relief of the symptoms of allergic asthma, asthmatic bronchitis, chronic bronchitis with emphysema, emphysematous bronchospasm. Also for the relief of bronchial asthma associated with hay fever, allergic rhinitis and nonseasonal upper respiratory allergies.

DOSAGE: Adults: one tablet every 3 or 4 hours, four to five times daily. Children over six: one half the adult dosage.

Available at all pharmacies.

FOR PROMPT EMERGENCY RELIEF **BRONKEPHRINE®** hydrochloride

(ethylnorepinephrine-Breon—10 cc. vials 2 mg./cc.)

"... far more than a substitute for epinephrine ..."[2]

BREON

GEORGE A. BREON & CO., NEW YORK 18, NEW YORK

1. Personal communication. 2. Foland, J. P.: Postgrad. Med. 18:397 (Nov.) 1955.

to know," says one top salesman. Adds the headquarters office: "If you think, sleep, eat, and breathe Nutrilite . . . if you are continually on the alert to find new prospects, you cannot dodge success."

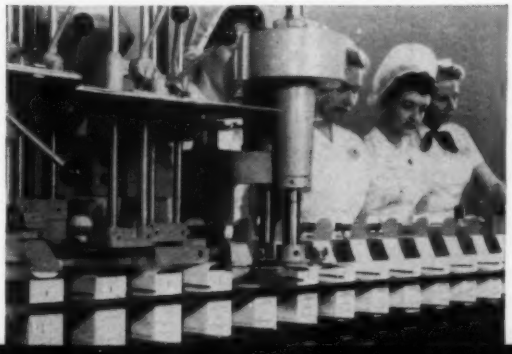
A good many of the Nutrilite distributors I've met seem to fall into a certain personality pattern. They're preoccupied with health. They often suffer from some such chronic discomfort as headaches or backache. They sometimes evidence a faint grudge against the medical profession. Above all, they resent what they believe to be A.M.A. and F.D.A. persecution.

But if you're tempted to warn your patients about Nutrilite, remember this: It's in a rather different class from some of the products being peddled to American food faddists. Nutrilite has cornered three-quarters of the door-to-door vitamin market partly because its makers and salesmen are dedicated to it.

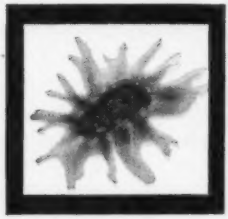
Aside from the unauthorized statements of some agents who don't follow the sales manual, the company's skirts are clean. Bright-eyed Carl Rehnborg has a staff of Ph.D. chemists doing experiments in his spotless laboratory. He and they are trying to prove that his concentrate increases an organism's resistance to stress. Meanwhile, the sales headquarters has plenty of proof that the product packs a big emotional appeal.

My guess is that no public education campaign will sway the true believers in Nutrilite. In a sleek package designed by Raymond Loewy, they have a cause and a bonanza—and they're happy as birds. END

THIS PRODUCTION LINE *is moving steadily to supply door-to-door salesmen with Nutrilite's new line of products: healthful cosmetics.*



keep the ulcer in protective custod



Mucotin arrests painful enzymatic action by covering inflamed or eroded gastric mucosa with a protective and soothing shield of *natural* mucin. At the same time, two proven antacids... evenly dispersed by the mucin... restore gastric pH to the optim range and keep it there for hours. Mucotin's acid barri provides continuing neutralization, eliminates pain an discomfort, assures prompt and prolonged relief in pept ulcer, hyperacidity, gastritis and pylorospasm. Dosage: pleasant-tasting tablets 2 hours after each meal or whenev symptoms are pronounced.

Formula: each Mucotin tablet contains: natural gastric mucin 160 mg. (2½ gr.), alumi hydroxide gel 250 mg. (4 gr.), magnesium trisilicate 450 mg. (7 gr.).

Mucotin

the antacid with natural gastric mu

WARNER CHILCOTT

MORRIS PLAINS, N.J.



Business Callers Wrecking Your Appointment Schedule?

Here are four ways, suggested by your colleagues, to get it back on the track

By Robert L. Brenner

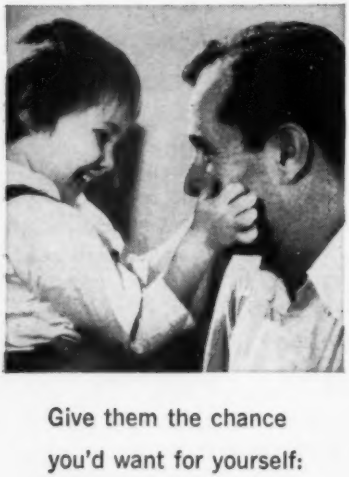


"My office appointment schedule is being knocked into a cocked hat by business callers," a young doctor complained to MEDICAL ECONOMICS recently. "An average of four salesmen, detail men, insurance adjusters, or other nonpatients drop in each day—most of them during my regular office hours. I'd hate to simply refuse to see any of them, but I may have to. What do you suggest?"

The physician's problem was dropped in my lap. So I made a quick check of doctors all across the country. "Are nonpatients disrupting your office hours?" I asked. "And if so, what are you doing about it?" The answers I got were summed up best by a New Jersey dermatologist:

"Sure, business callers can

With Your Help,
THE MENTALLY ILL CAN COME BACK



Give them the chance you'd want for yourself: a job, a home, a place in the community.

NATIONAL ASSOCIATION FOR MENTAL HEALTH

SUPPORT YOUR MENTAL HEALTH ASSOCIATION

throw any doctor's appointment schedule out of whack," he said. "But it's the doctor's own fault if they do. There are plenty of simple ways to solve the problem."

Here are the four most common solutions doctors told me they are using. You can choose one that fits your practice best, or use two or three in combination.

1. Reserve a regular time each week for business callers.

"I see all nonpatients from 3 to 4 on Monday, Wednesday, and Friday afternoons—a time I call my nonprofessional office hours," says a G.P. in Harrisburg, Pa. "I'm usually through with patients by then, and I can give the salesmen my undivided attention. My office help likes the scheme too. My time with business callers gives my aides a chance to finish up chores without interruptions from me or from patients."

This "nonprofessional office hours" plan has also cleared up some problems for a pediatrician in Brockton, Mass. "I used to save one morning at the office each week for going over records," he says. "But salesmen started dropping in then because they knew no patients would be there. Soon they were cutting so heavily into

ANNOUNCING a potent, low-dose antihistamine

for allergic patients who must
remain active and alert

NEW **HISPRIL***

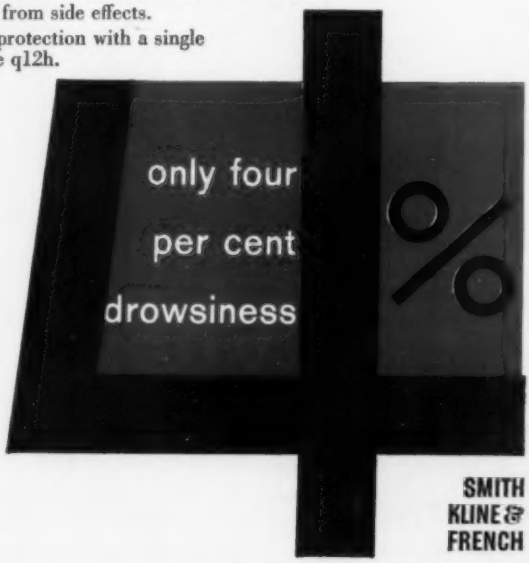
brand of diphenylpyraline hydrochloride

Spansule® 5 mg. and Tablets 2 mg.

brand of sustained release capsules

ADVANTAGES:

1. Often works where other antihistamines have failed.
2. Unusual freedom from side effects.
3. All-day, all-night protection with a single 'Spansule' capsule q12h.



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*Trademark

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greater specificity of tranquilizing action —divorced from such "diffuse" effects as anti-emetic action —explains why

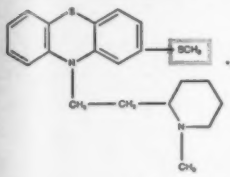
Mellaril

THIORIDAZINE HCl

is virtually free of such toxic effects as jaundice, Parkinsonism, blood dyscrasia

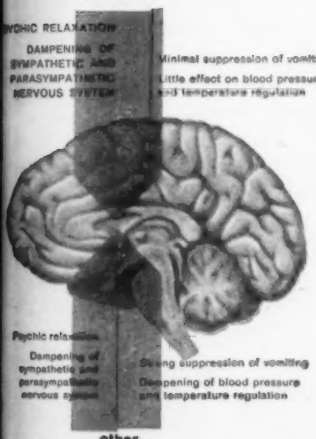
"Thioridazine [MELLARIL] is as effective as the best available phenothiaz but with appreciably less toxic effects than those demonstrated with of phenothiazines. . . . This drug appears to represent a major addition to safe and effective treatment of a wide range of psychological disturban seen daily in the clinics or by the general practitioner."*

reater specificity of tranquilizing action results in fewer side effects



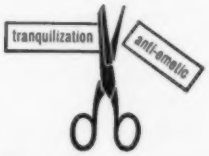
The presence of a thiomethyl radical ($S\text{-}CH_3$) is unique in Mellaril and could be responsible for the relative absence of side effects and greater specificity of psychotherapeutic action. This is shown clinically by:

MELLARIL



other phenothiazine-type tranquilizers

1 **A specificity of action on certain brain sites in contrast to the more generalized or "diffuse" action of other phenothiazines. This is evidenced by a lack of appreciable anti-emetic effect.**



2 **Less "spill-over" action to other brain areas — hence, absence of undue sedation, drowsiness or autonomic disturbances.**

3 **A notable absence of extrapyramidal stimulation.**

4 **Lack of impairment of patient's normal drive and energy.**

5 **Virtual freedom from such toxic effects as jaundice, photosensitivity, skin eruptions, blood forming disorders.**

Indication	Usual Starting Dose	Total Daily Dosage Range
ADULTS: Mental and Emotional Disturbances:		
MILD—where anxiety, apprehension and tension are present	10 mg. t. i. d.	20-60 mg.
MODERATE—where agitation exists in psychoneuroses, alcoholism, intractable pain, senility, etc.	25 mg. t. i. d.	50-200 mg.
SEVERE—in agitated psychotic states as schizophrenia, manic depressive, toxic psychoses, etc.:		
Ambulatory	100 mg. t. i. d.	200-400 mg.
Hospitalized	100 mg. t. i. d.	200-800 mg.
CHILDREN: BEHAVIOR PROBLEMS IN CHILDREN	10 mg. t. i. d.	20-40 mg.

ellaril Tablets, 10 mg., 25 mg., 100 mg.

tfield, A. M.: Scientific Exhibit, American Academy f General Practice, San Francisco, April 6-9, 1959.

SANDOZ

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my record-review time that I had to tell them to stop.

"Now I see business callers only at the end of my regular morning office hours. I limit each caller to ten or fifteen minutes, and it works out fine."

The scheme works equally well for doctors in group practice, the head of a seven-physician clinic in Southern Virginia points out. "We all get together to see business callers at noon on Fridays," he explains. "With seven of us listening at once, the salesmen know it's important to keep their talks right to the point. They also know that other business callers are waiting, so they keep their presentations brief. In return, we make a point of inviting them back soon."

2. See business callers by appointment only.

"I give all salesmen appointments in advance for 1 P.M.," says an Alameda, Calif., surgeon. "I see only one per day, and I limit him to fifteen minutes. I never keep these callers waiting unless I'm delayed in surgery or have an emergency. They like the system because they can count on seeing me at a set time, and they know just how long they can stay."

A Detroit internist says he too uses this by-appointment-only system for business callers. "If one drops in, my aide tells him politely he'll have to make an appointment. Usually he's glad to do so, because then he knows I'll be ready to listen to him when he does see me."

3. See business callers in a separate room.

Here's another system that'll work for both solo practitioners and groups. "We have a nine-doctor clinic," says a Vancouver, Wash., EENT man. "When a detail man comes in, our receptionist shows him to a room we've set aside just for that purpose. Then as many of us as can drop in to see him when we get a spare moment. We've been using this system for two years and we think it's the best."

An Arizona OB/Gyn. man agrees. "There's usually an empty room in my office," he says, "and I have my aide show business callers there to wait. When I get a free minute—as when a patient is getting prepared for examination—I slip in and see the caller. That way I can work him in and still not keep patients waiting."

4. Have your aide pre-interview business callers. *More*



SURFADIL®

promptly relieves minor skin irritations

Summertime skin woes—poison ivy, insect bites, and sunburn—yield readily to the soothing effects of Lotion Surfadil. The anesthetic component stops pain and itch almost instantly. An odorless, skin-colored coating of antihistamine and adsorbent remains to maintain relief for hours.

This coating also helps *prevent* sunburn in your more sensitive patients. The ingredient titanium dioxide acts as a translucent "shield" to screen the sun's rays.

Each 100 cc. contain:

Histadyl™	2 Gm.
Surfacaine®	0.5 Gm.
Titanium Dioxide	5 Gm.

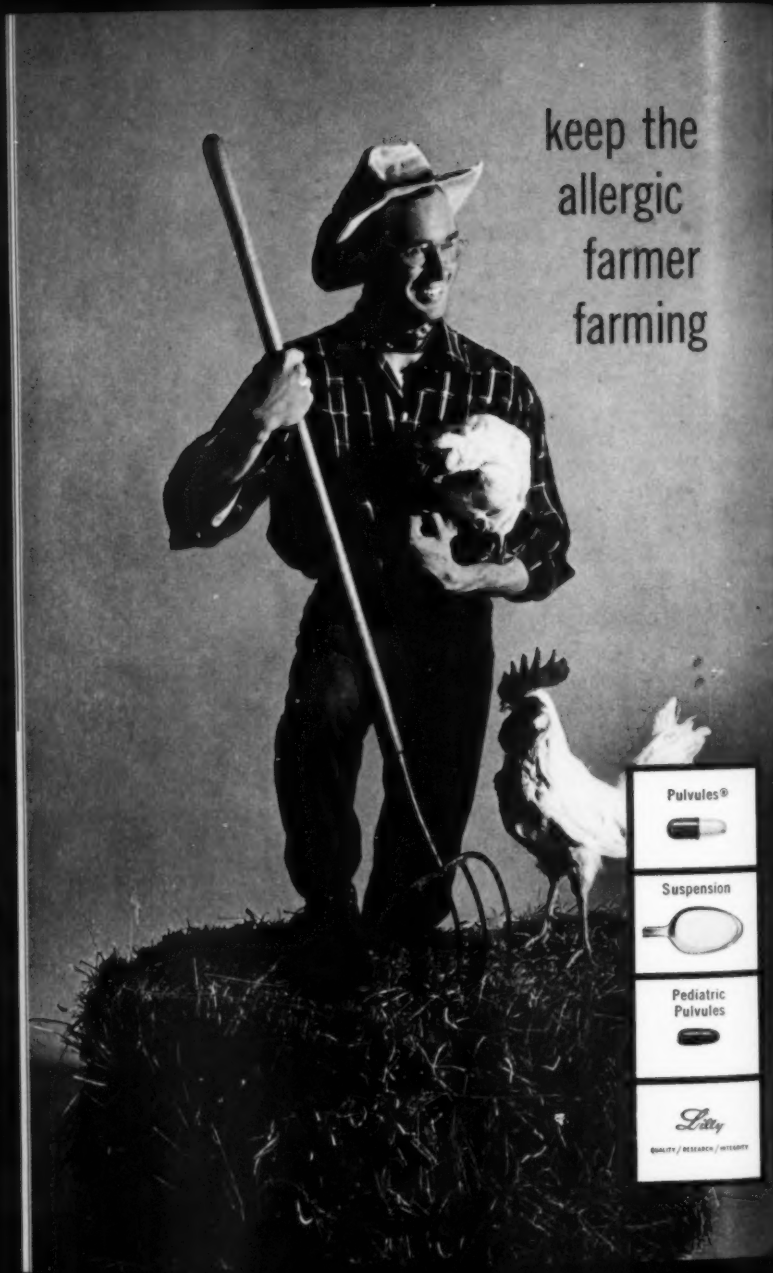
Available in spillproof, unbreakable plastic containers of 75 cc.

Surfadil® (cyclomethycaine and thenylpyramine, Lilly)
Histadyl™ (thenylpyramine, Lilly)
Surfacaine® (cyclomethycaine, Lilly)

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Suspension
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CO-PYRONIL™

provides quick relief that lasts and lasts

Just two or three Pulvules Co-Pyronil daily will usually keep your hay-fever patients symptom-free and on the job all day long. Not *just* an antihistamine, Co-Pyronil is a triple combination that assures more complete relief of hay fever and other allergies.

Each Pulvule contains:

vasoconstrictor, Clopane® Hydrochloride, to complement the action of two antihistamines by opening swollen nasal passages.

fast-acting antihistamine, Histadyl™, to provide relief usually within fifteen to thirty minutes.

long-acting antihistamine, Pyronil®, to maintain relief for eight to twelve hours.

For full description, see page 698 of your 1959 *PDR.*

Co-Pyronil™ (pyrrobutamine compound, Lilly)
Clopane® Hydrochloride (cyclopentamine hydrochloride, Lilly)
Histadyl™ (thenylpyramine, Lilly)
Pyronil® (pyrrobutamine, Lilly)

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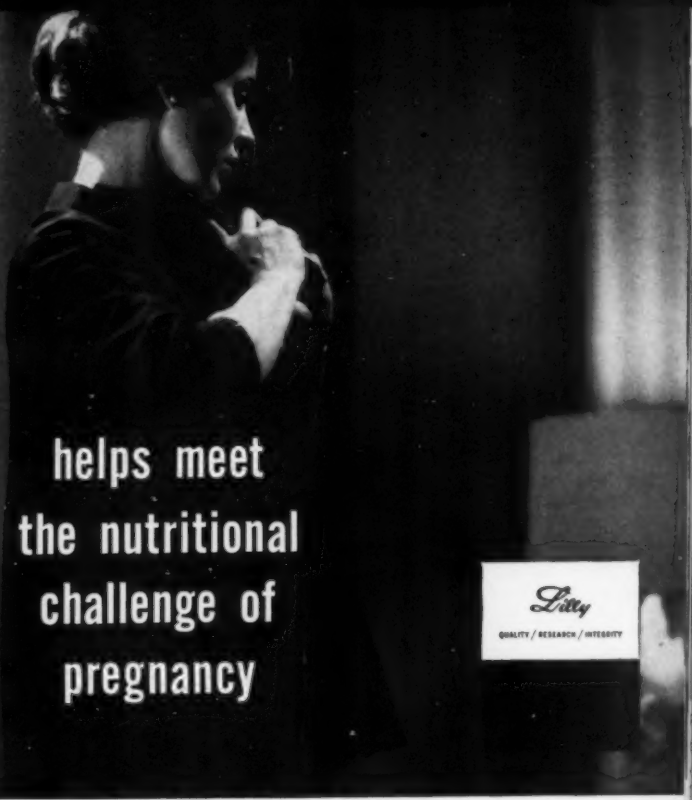
"I keep a very tight appointment schedule," a New York internist says, "and I simply can't permit any interruptions. My aide spends about fifteen minutes with all salesmen. She takes any literature or samples they leave and files it according to a system we've set up. Then if I ask 'What's new for such-and-such?' she has it in my hands in seconds. If a business caller insists on seeing me personally, she tells me about him, and I sometimes make an appointment for him later."

You've noticed that these four systems have one thing in common. They let the doctor see business callers without making his patients wait and without disrupting his appointment schedule. You'll probably find any one of them, or a combination of several, is better than simply working such callers in between patients. You will, that is, unless you agree with the Arkansas G.P. I talked with. "When business callers drop in, I work them in between patients just as soon as I can," he told me. "I find their sales talks are the best relaxation there is from listening to patients' complaints." END



© MEDICAL ECONOMICS
CARTOON: LARRY KATZMAN
CAPTION: F. W. KNOCH, M.D.

"You mean you're not goin' to look in my ears after she washed 'em."



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when the "parasitic fetus" drains maternal stores

Even *in utero*, baby will have his way. Nature favors his need to build up a store of nutrients for his own biochemical processes—often at the expense of the mother-to-be.

Supplementation of her normal dietary intake with the comprehensive Compren formula will not only help overcome maternal deficiency but will also insure an adequate supply to the "parasitic fetus." Prescribe 1 to 3 Pulvules® daily for better health and fewer complications for both mother and child.

Compren® (prenatal dietary supplements, Lilly) 808000

LILLY VITAMINS . . . "THE PHYSICIAN'S LINE"

Work With Osteopaths? More M.D.s Are Doing It

The A.M.A. ban hasn't been removed—but it's crumbling around the edges. From medical leaders, from M.D.s on Main Street, here's private testimony that proves it

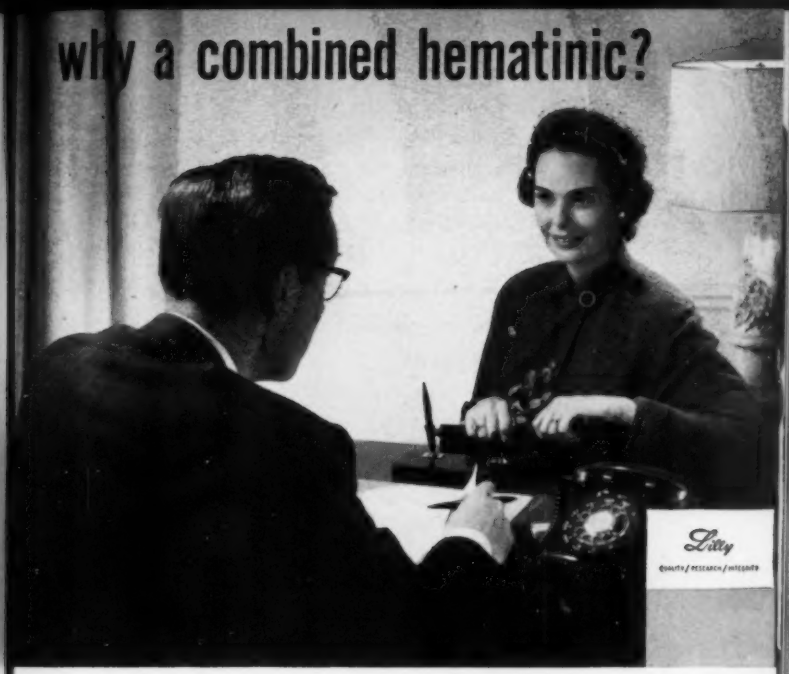
By John R. Lindsey

"I've been trying to make sense out of all the ethical gobbledygook about doctors of medicine associating with doctors of osteopathy," a radiologist told me a few days ago. "The best I can figure out is that it's ethical for me to consult with an osteopath in the morning, but it's unethical for me to consult with the same osteopath in the afternoon.

"How come? Well, in the morning I'm in my office at the county hospital. Osteopaths are members of the medical staff there—a right they hold under the state law. It's my job as head of the X-ray department to work with them. Because it's required by law, it's ethical, according to the A.M.A.

"But in the afternoon, when I'm in my own private office, it's a different situation. Then, even if an osteopath who's consulted me at the hospital comes in, I've got to say, 'Sorry, Doctor, I can't talk to you professionally now. It's unethical.'

"I want to do what's right," the



both blood picture and patient respond to TRINSICON®

Investigators[1,2] have determined that low serum iron may be accompanied by insidious vitamin B_{12} deficiencies which result from subnutrition, increased demand, or lack of intrinsic factor. Coexisting vitamin C deficiencies also have been found.[3]

These studies suggest that an anemia may be multiple in nature—that optimum results would be derived from a combination of therapeutic agents.

Trinsicon offers therapeutic quantities of all known hematinic factors. Prescribe two Pulvules® daily to provide assured response in all treatable anemias.

Trinsicon® (hematinic concentrate with intrinsic factor, Lilly)

1. A. M. A. Arch. Int. Med., *99*:346, 1957.
2. Am. J. Obst. & Gynec., *70*:1309, 1955.
3. Lancet, *1*:448, 1957.

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radiologist concluded, "but I can't help wondering: Is this ethical ban on associating voluntarily with D.O.s really in the patient's best interest? Some of my colleagues say yes, some say no, and the A.M.A. apparently says both. So we're all working out our own answers."

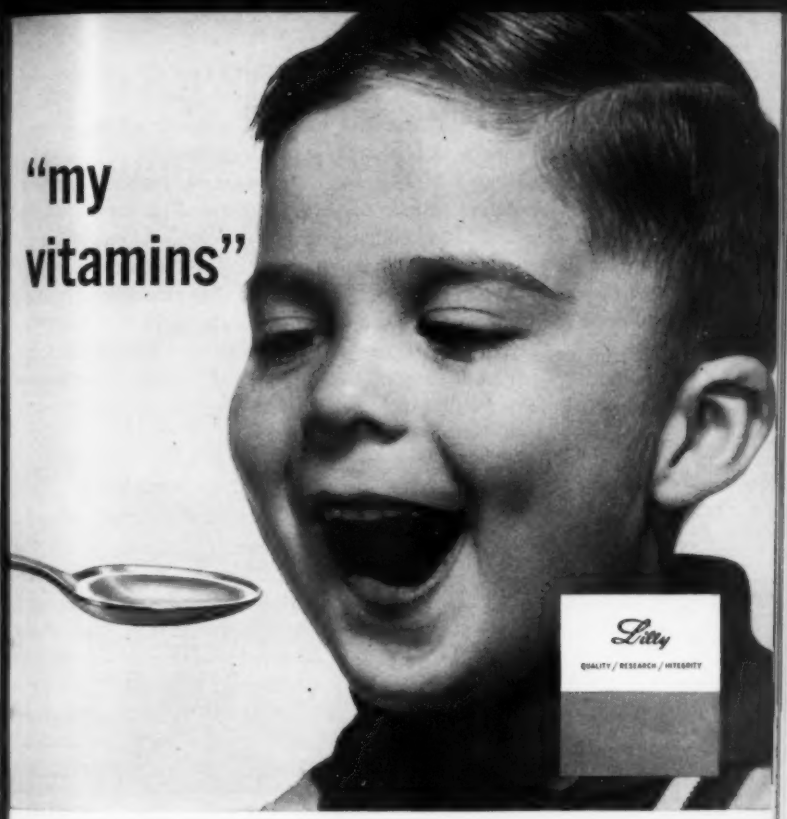
The official A.M.A. answer is

OSTEOPATHS' SCOPE OF PRACTICE

A total of 9,514 D.O.s now hold "unlimited" licenses to practice medicine and surgery and to prescribe drugs on the same terms as M.D.s. Another 2,833 D.O.s hold "limited" licenses—usually meaning that they can't perform major surgery or prescribe drugs. The state-by-state breakdown:

State	Unlimited	Limited	State	Unlimited	Limited
Ala.	0	3	Mo.	1,122	0
Alaska	0	0	Mont.	0	46
Ariz.	62	40	Neb.	9	52
Ark.	0	24	Nev.	27*	0
Calif.	1,969	111	N.H.	27	0
Colo.	368	0	N.J.	324	53
Conn.	14	46	N.M.	104	0
Del.	25	0	N.Y.	369	91
D.C.	12	6	N.C.	0	31
Fla.	365	0	N.D.	0	14
Ga.	0	73	Ohio	624	130
Hawaii	1	13	Okla.	117	240
Idaho	0	41	Ore.	131*	0
Ill.	26	304	Pa.	475	727
Ind.	126	41	R.I.	9	61
Iowa	74	372	S.C.	0	8
Kan.	138	55	S.D.	6	41
Ky.	41	0	Tenn.	69	0
La.	0	14	Tex.	613	0
Me.	268	0	Utah	8	12
Md.	0	19	Vt.	7	27
Mass.	271	7	Va.	20	11
Mich.	1,277	0	Wash.	149	14
Minn.	0	82	W. Va.	113	0
Miss.	0	5	Wis.	138	19
			Wyo.	16	0

*Unlimited scope claimed by osteopaths, but legally in dispute. Source: A.M.A. Law Division.



HOMICEBRIN®... homogenized multiple vitamins, taste-tested for "tot-appeal"

Willful youngsters are often quite particular about their personal vitamin supplement. However, even the most fastidious of them welcome pleasant-tasting Homicebrin into their daily routine.

This boon to harried parents is also reassuring to the physician. Homicebrin supplies eight essential vitamins, potency-protected by homogenization and careful buffering. To be certain your "tot-age" patients take and receive their full vitamin requirements, specify Homicebrin.

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LILLY VITAMINS . . . "THE PHYSICIAN'S LINE"

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that the ethical ban still stands. But it stands more shakily than before, because the A.M.A. Judicial Council—chief arbiter of medical ethics—recommended just this past June that the ban be dropped.

The A.M.A. House of Delegates didn't accept this recommendation. Instead, it adopted a substitute resolution that my radiologist-friend found almost impossible to interpret. A bit later, therefore, I asked Dr. E. Vincent Askey of Los Angeles, the new A.M.A. president-elect, for his interpretation.

"Did the A.M.A. recognize osteopaths, or didn't it?" I asked.

Open-Door Policy

"No, we didn't—not in the sense that we recognize full-fledged M.D.s," Dr. Askey replied. "But we left the door open to future recognition."

"May M.D.s now consult freely with D.O.s in the states where osteopaths are fully licensed to practice medicine and surgery?"

"Not as of today, they can't," said Dr. Askey. "Not ethically, at least. But maybe tomorrow they can. That's what we're working toward. We took a few short steps in that direction rather than try to cover all the ground in one long leap."

Since then, seeking further clarification, I've been talking with other A.M.A. insiders. I've found more tolerance toward osteopaths than the official resolution reflects. And I've gained a better understanding of the steps that are now being taken to permit M.D.s and D.O.s to work together.

New Machinery

One such step is the setting up of liaison machinery at the top level. "The American Osteopathic Association can use it to work out with the A.M.A. some of the national problems of interprofessional relations," says Dr. Homer L. Pearson Jr. of Miami, chairman of the A.M.A. Judicial Council. "Certainly that much is new."

M.D.s Can Teach Them

Another step is the A.M.A. announcement that it's ethical for M.D.s to teach in an osteopathic college that's "in the process of being converted into an approved medical school under the supervision of the A.M.A. Council on Medical Education and Hospitals." This pleases Ca-



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Ultran (1) allays apprehension and anxiety, (2) relieves neuromuscular tension, and (3) enhances the effectiveness of analgesic therapy. It is well tolerated, notably safe, and chemically unique.

Supplied in Pulvules® of 300 mg. (usually 1 t.i.d.) and scored tablets of 200 mg. (usually 1 q.i.d.).

Ultran® (phenaglycodol, Lilly)

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ifornia medical men. As I understand it, they have hopes that the Los Angeles College of Osteopathic Physicians and Surgeons may soon be ripe for such conversion.

If this happens, I've an idea it could set a national pattern for the possible conversion of other osteopathic colleges into Grade-A medical schools.

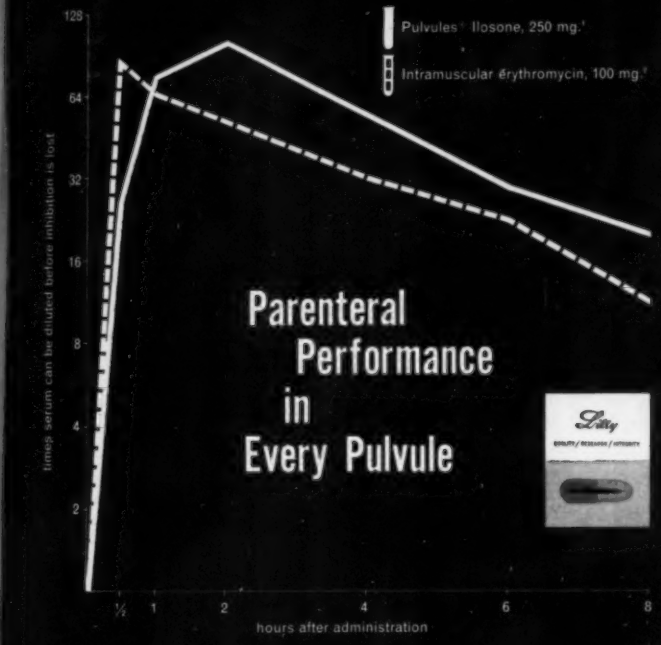
Such a development would please the A.M.A. Judicial Council too. Says Chairman Pearson: "We believe that all osteopaths should be taught by doctors of medicine. If we put medical teachers in osteopathic schools, soon there'll be no more osteopathic schools. They'll become true medical schools."

Some M.D.s are known to be teaching in osteopathic schools already. Do they risk being de-



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"He wants *me* to make the house call."



ILOSONE™ assures a decisive response in common bacterial infections

Parenteral potency—The graph above shows that Ilosone provides antibacterial serum levels comparable to those obtained with intramuscular therapy.

Parenteral certainty—In more than a thousand determinations, in hundreds of patients studied, Ilosone has never failed to provide significant antibacterial levels in the serum.

The usual dosage for adults and children over fifty pounds is 250 mg. every six hours, but doses of 500 mg. or more may be administered safely every six hours in more severe infections. For optimum effect, administer on an empty stomach. Supplied in Pulvules of 250 mg. (For children under fifty pounds, a 125-mg. Pulvule is also available.)

Ilosone™ (propionyl erythromycin ester, Lilly)

1. Antibiotic Med. & Clin. Therapy, *5*:609, 1958.
2. Data from Antibiotics Annual, p. 269, 1954-1955.

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clared unethical for jumping the gun? Here's what Dr. Pearson says:

Societies Won't Fight It

"I suspect that with the green light on for osteopaths—or maybe it's only an amber light—a lot of county and state medical societies are not going to make an issue of the ethics question locally."

Does this apply also to M.D.s who consult with D.O.s and accept referrals from them? "Don't ask me," says Dr. Pearson. "It depends on the local medical society. All I can say is this:

"It's pretty hard for the public to understand what we medical men are talking about when we say it's unethical for us to accept an osteopath's request for consultation when he's got a patient in need of a specialist's attention. Is this the way to protect the public from inferior medical care? I wonder."

It's O.K. in Kansas

Some local medical societies have stopped wondering. According to another A.M.A. insider:

"In Kansas it's not considered unethical now for medical men to consult with osteopaths even voluntarily. Are we to say that the whole Kansas state medical society is unethical? Who's to blow the whistle?

"We know that many M.D.s consult with osteopaths in other states too. We know that D.O.s send tissue to pathologists and get reports back. Is this unethical?

Technically, it is. But if the county society doesn't think so, who's going to make it change its mind?"

A Double-Edged Sword

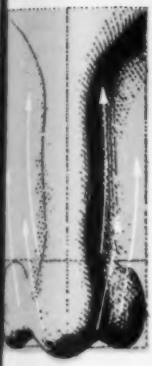
This sounds like local option —and increasingly it is. But local option cuts both ways. If a local medical society feels that the ghost of Andrew Taylor Still, the founder of osteopathy, has not been laid, it can compel its members to stay away from D.O.s.

In a dozen or so states where most osteopaths are not fully licensed, many doctors are determined to uphold the traditional A.M.A. ban. As Dr. Ezra E. Koebee, president of the Nebraska State Medical Association, says:

"All we ask is to be left alone. Up to now we've successfully resisted the cultists. It would be

penetrating

NOSE-OPENER BIOMYDRIN®



speeds medication to the site of irritation

penetrates, causing prompt dispersion of mucoid secretions. This deep infiltration allows all therapeutic agents to remain active for prolonged periods.



spreads almost instantly.

clears the air passages.

decongests without causing rebound congestion.

controls the allergic component.

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safe—no pediatric dosage form is needed.

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Neomycin sulfate 0.1%
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Thonzylamine HCl 1.0%
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15 ml. atomizer or dropper bottle.

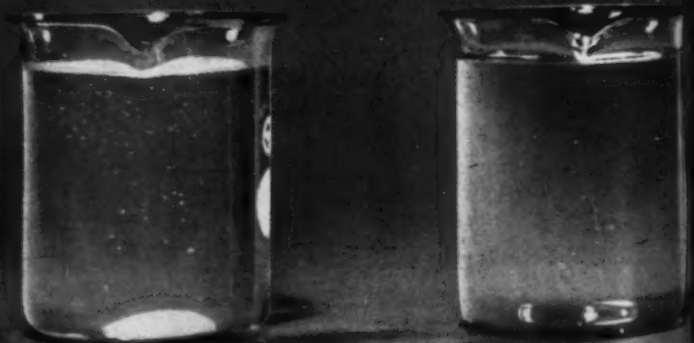
Also, **Biomydrin® F nasal spray** with hydrocortisone alcohol 0.02%—useful in the most stubborn cases of edema and inflammation. 15 ml. atomizer.

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avoid the risk of insoluble irritating aspirin particles

Chief among the drawbacks to aspirin usage is gastric intolerance. This ranges from mild upset and "heartburn" to severe hemorrhagic gastritis.[1-10] Studies performed in conjunction with gastrectomy[4-6] and gastroscopy[3] have shown insoluble aspirin particles firmly adherent to the gastric mucosa and imbedded in the rugae. Reactions varying from mild hyperemia to erosive gastritis have been reported to occur in the areas immediately surrounding these adherent particles.[3-6,9] This is reported to be particularly true in patients with peptic ulcer.

CALURIN is the freely-soluble, stable calcium aspirin complex. Its high solubility forestalls gastric irritation or damage.



Regular aspirin crystals 24 hours after being mixed into water.

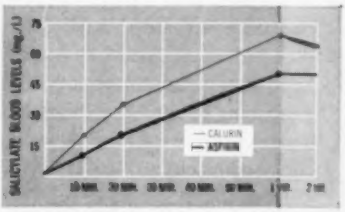
Calurin crystals in solution one minute after being mixed into water.

CALURIN*

STABLE SOLUBLE CALCIUM-ACETYLSALICYLATE-CARBAMIDE



Particle-induced ulceration — section through lesion found in gastrectomy specimen. An aspirin particle was found firmly imbedded in this undermined erosion. Such lesions may be associated with the relative insolubility of aspirin, which remains in particulate form after dispersion in gastric contents.



Calurin, being freely soluble, is promptly available for absorption into the systemic circulation. Salicylate blood levels in 12 subjects receiving both Calurin and plain aspirin were found to rise more than twice as high within ten minutes following Calurin. Also, these levels persisted higher for at least two hours.[11]

CALURIN is the aspirin of choice, especially when high-dosage, long-term therapy is indicated:

1 High solubility forestalls gastric irritation or damage. This advantage is of special importance in arthritis and other conditions requiring high-dosage, long-term therapy.

2 Produces high salicylate blood levels rapidly for prompt analgesic, anti-pyretic, anti-arthritic effect.

3 Sodium-free — for safer long-term therapy.

4 Flavored: can be chewed or dissolved in the mouth without water if desired — an advantage for patients requiring aspirin administration during the night and for pediatric patients.

Dosage: Each tablet of Calurin is equivalent to 300 mg. (5 gr.) of acetylsalicylic acid. For relief of pain and fever in adult patients, the usual dose of Calurin is 1 to 3 tablets every 4 hours, as needed; in arthritic states, 2 or 3 tablets 3 or 4 times daily; in rheumatic fever, 3 to 5 tablets 4 or 5 times daily. For children over 6 years, the usual dose is 1 tablet every 4 hours; for children 3 to 6 years, ½ tablet every 4 hours, as required. Not recommended for children under 3.

REFERENCES: 1. Waterson, A. P.: Aspirin and gastric haemorrhage, Brit. M. J. 2:1531, 1955. 2. Douthwaite, A. H., and Lintott, G. A. M.: Gastroscopic observation of the effect of aspirin and certain other substances on the stomach, Lancet 2:1222, 1938. 3. Editorial Comments: The effect of acetylsalicylic acid (aspirin) on the gastric mucosa, Canad. M. A. J. 80:47, 1959. 4. Muir, A., and Cossar, I. A.: Aspirin and ulcer, Brit. M. J. 2:7, 1955. 5. Muir, A., and Cossar, I. A.: Aspirin and gastric haemorrhage, Lancet 1:539, 1959. 6. Schneider, E. M.: Aspirin as a gastric irritant, Gastroenterology 33:616, 1957. 7. Bayles, T. B., and Tenckhoff, H.: Salicylate therapy in rheumatic diseases, Scientific Exhibit, Ann. Mtg. A. M. A., San Francisco, Calif., June, 1958. 8. Batterman, R. C.: Comparison of buffered and unbuffered acetylsalicylic acid, New Eng. J. M. 258:213, 1958. 9. Cronk, G. A.: Laboratory and clinical studies with buffered and nonbuffered acetylsalicylic acid, New Eng. J. M. 258:219, 1958. 10. Editorial: Aspirin plain and buffered, Brit. M. J. 1:349, 1959. 11. Smith, P. K.: Plasma concentration of salicylate after the administration of acetylsalicylic acid or calcium acetylsalicylate to human subjects, Report submitted to Smith-Dorsey from Dept. of Pharmacology, Geo. Washington Univ. School of Medicine, Washington, D. C., Sept. 5, 1958.*TRADEMARK

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disastrous if those states that haven't done any resisting were to force us to open our doors to D.O.s."

And Dr. John P. Culpepper Jr. of Hattiesburg, Miss., adds: "I don't doubt that the A.M.A. Judicial Council means it when it says that some osteopaths are practicing scientific medicine. All I want to know is: How do we tell the good osteopaths from the bad osteopaths?

"We know that a majority of states license osteopaths to practice without limitation.* But I feel strongly that it's unsound to change our policy toward cultists on the basis of licensing criteria. Remember, *chiropractors* are licensed in all but four states!"

*See chart on page 144.

Less Confusion Ahead?

Considering all these cross-currents, what can I report to the radiologist I quoted at the beginning? Simply this:

The way the wind is blowing, it seems likely that before long what's ethical for him in the morning will also be ethical in the afternoon. END

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to give
ambulatory patients
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SENSIT

CHLOROMYCETI

MANY STRAINS OF HOSPITAL STAPHYLOCO

The organism that is often involved in minor and major bacterial infections[1]—staphylococcus aur
still sensitive to CHLOROMYCETIN in a great many instances.[2,3] One recent survey, for example,
that, in most hospitals, the proportion of strains of staphylococci resistant to chloramp
[CHLOROMYCETIN] is "...generally less than 10%."[4]

In a comparative hospital study, extensive use of CHLOROMYCETIN over a five-year period did no
in increased resistance of staphylococci to the drug.[5] Other investigators describe as impressive "...
sistently high sensitivity pattern maintained by staphylococcal strains isolated in hospitals where us
antibiotic has not been curtailed."[6]

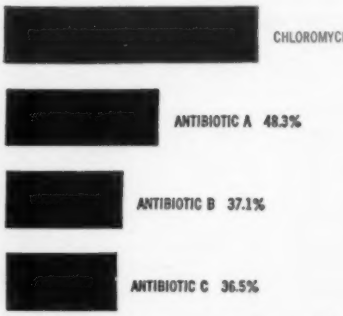
CHLOROMYCETIN (chloramphenicol, Parke-Davis) is available in a variety of forms, including Kap
250 mg., in bottles of 16 and 100.

CHLOROMYCETIN is a potent therapeutic agent and, because certain blood dyscrasias have been associa
its administration, it should not be used indiscriminately or for minor infections. Furthermore, as wit
other drugs, adequate blood studies should be made when the patient requires prolonged or intermittent

REFERENCES: (1) Brown, J. W.: *J.A.M.A.* *166*:1185, 1958. (2) Schneierson, S. S.: *J. Mt. Sinai Hosp. New York* 25
(3) Goslings, W. R. O., & Büchli, K.: *Arch. Int. Med.* *102*:691, 1958. (4) Blair, J. E., & Carr, M.: *J.A.M.A.* *166*:1192, 1958. (5)
in Welch, H., & Martí-Ibañez, F.: Antibiotics Annual 1957-1958, New York, Medical Encyclopedia, Inc., 1958, p. 783. (6)
T. E., & Wisseman, C. L., Jr.: Chloromycetin (Chloramphenicol), New York, Medical Encyclopedia, Inc., 1958, p. 9. (7)
Ulrich, E. W.: *Antibiotics & Chemother.* *9*:38, 1959.

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IN VITRO SENSITIVITY OF STAPHYLOCOCCUS AUREUS TO CHLOROMYCETIN AND TO THREE OTHER ANTIBIOTICS*



*Adapted from Suter & Ulrich.[1] These antibiotics were tested by the tube dilution method, using a concentration of 12.5 mcg/ml.

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How I Weed Out Patients I Don't Want

The largest possible practice isn't the best practice, this M.D. points out. Here's his system for screening new patients

BY JOHN STUYVESANT, M.D.

Let's face it: There *are* undesirable patients! And I dare say the average physician would gladly part with some of his income if he could get rid of such patients gracefully. Wouldn't you?

If so, my experience may interest you. I've found it's entirely possible for a doctor to build his practice on the basis of quality instead of quantity. Each day's work has become much more satisfying to me since I've learned how to screen out some of the patients I'd rather not treat.

Perhaps you'll agree that the largest possible practice isn't the most satisfactory practice. But is it ethical to limit your patient-load to the types of patient you prefer?

Definitely, it is. "A physician

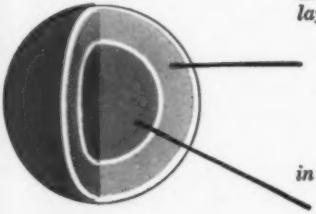


THE AUTHOR *is a West Coast practitioner. He uses a pen name here so he can be candid about the reasons he doesn't accept certain patients.* *This article is copyrighted © 1959 by Medical Economics, Inc. It may not be reproduced, quoted, or paraphrased in whole or in part in any manner whatsoever without the written permission of the copyright owner.*



the complaint: "nervous indigestion"

the diagnosis: any one of several nonspecific gastrointestinal disorders requiring relief of symptoms by sedative-antispasmodic action with concomitant digestive enzyme therapy. **the prescription:** a new formulation, incorporating in a single tablet the actions of Donnatal and Entozyme. **the dosage:** two tablets three times a day, or as indicated.



the formula: *in the gastric-soluble outer layer:*

Hyoscyamine sulfate	0.0518 mg.
Atropine sulfate	0.0097 mg.
Hyoscine hydrobromide	0.0033 mg.
Phenobarbital (1/8 gr.)	8.1 mg.
Pepsin, N.F.	150 mg.

in the enteric-coated core:

Pancreatin, N.F.	300 mg.
Bile salts	150 mg.

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is free to choose whom he will serve," says Chapter II, Section 3 of the A.M.A's Principles of Medical Ethics (1955 edition). And the A.M.A. Judicial Council adds: "Therefore the physician whom the patient chooses may decline to serve when he is chosen, or *the chosen physician may be unavailable for many reasons.*"

The italics are mine. Shortly I'll show you just how I'm "unavailable for many reasons" to the wrong patients. First, though, how do I spot the minority of undesirable patients who come to me?

I can't hope to spot them all. But if I have serious doubts about a newcomer, I ask myself any of these questions that seem to apply:

Yardsticks for Patients

1. How did the new patient select me as his doctor? I beware of the walk-ins who were lured by my sign or by a glance at the list of doctors in the telephone book. These people haven't bothered to check my credentials. They care little about my professional ability. My name happens to have an M.D. after it—so I was "chosen."

Occasionally such a walk-in may become a good patient. But more often he'll forget my name as easily as he has learned it. Then he'll wander toward the next name he comes across.

2. How settled is the patient in the community? If he moved six times last year, he can usually be expected to be on the prowl again shortly.

Such an itinerant not only is suspect financially; he probably isn't going to stay long enough to let me (or the next doctor) become his personal physician.

The Back-Slapping Test

3. How familiar does the patient act on first acquaintance? Too familiar? I beware the back-slapper, the guy who calls me "Doc."

Why? Because I've noticed that a person with a personality like that is usually fickle. He may end up doing me more harm than good. I'm his buddy just so long as everything is going *his* way. If I cross him once, he'll be as ready to talk about me behind my back as he is to glad-hand me today.

4 How demanding does the prospective patient appear to be? The one who seems to expect special attention may turn out to

APRIL · 1959

PDR

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2nd

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to

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WE TURN THE PAGE . . .

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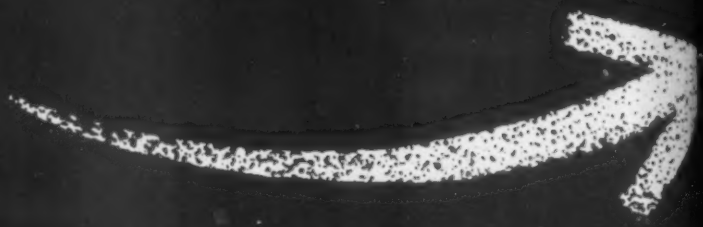
NUMBER THREE COMING UP, DOCTOR!

Your April issue (No. 2) of the PDR Quarterly Supplement is now out of date. Several new drug products have come on the market since it was published.

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Discard your April issue—and the January issue, if you still have it—when you receive your new PDR Quarterly Supplement. Then you'll need to refer to only one source for information about drugs that have come on the market since your PDR annual volume was published.

Look for the July issue of the PDR Quarterly Supplement in the mail. Keep it with your PDR annual volume for quick reference.



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JULY · 1959

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be one of my strongest supporters both financially and in referrals. But I have to balance that possibility against the extra time, effort, and headaches he's certain to cost.

While I'm spending half my morning acting out the role of doctor-adviser to this one patient, six others may be fidgeting in my waiting room. How do I know they won't up and leave while I'm dusting out the red carpet for one V.I.P. in my inner office?

A Good Credit Risk?

5. How trustworthy does the patient seem financially? I don't mean his ability to pay at the moment. But does he impress me as apt to be dependable about credit over the long run?

No doctor wants to encourage a deadbeat clientele. Once the word gets out, they'll flock to you in droves!

A well-meaning patient will usually be anxious to tell me if he's unable to pay. And he'll be anxious to add when and how he expects to be able to meet my bill.

6. How many other doctors has the patient visited before honoring me? The patient who's a "medical shopper" obviously isn't going to help provide a solid foundation for my practice.

I could tell myself that he has come to me after trying the others because he thinks I'm the best. But I don't flatter myself! The odds are that he'll be with me briefly and then journey ever onward.

7. How much rapport do I feel I can establish with the new patient? Let's say I've put my best medical foot forward, yet the patient gives me a skeptical stare. He's just "not with it." He challenges me to show him.

I'll have my work cut out to convince this one that I know what I'm doing. Is it going to be worth the battle? Sometimes it isn't.

So much for my "unwanted" list. I'm not maintaining that there's any such thing as the "ideal" patient or the "ideal" practice. But if a doctor wants to keep the undesirables to a minimum, it's in his province to do so.

How? You'll find my specific suggestions below. Admittedly, they may not be appropriate for you. But please understand that I use these tactics very selectively. They're for patients whom I'm



Like oil on trouble water

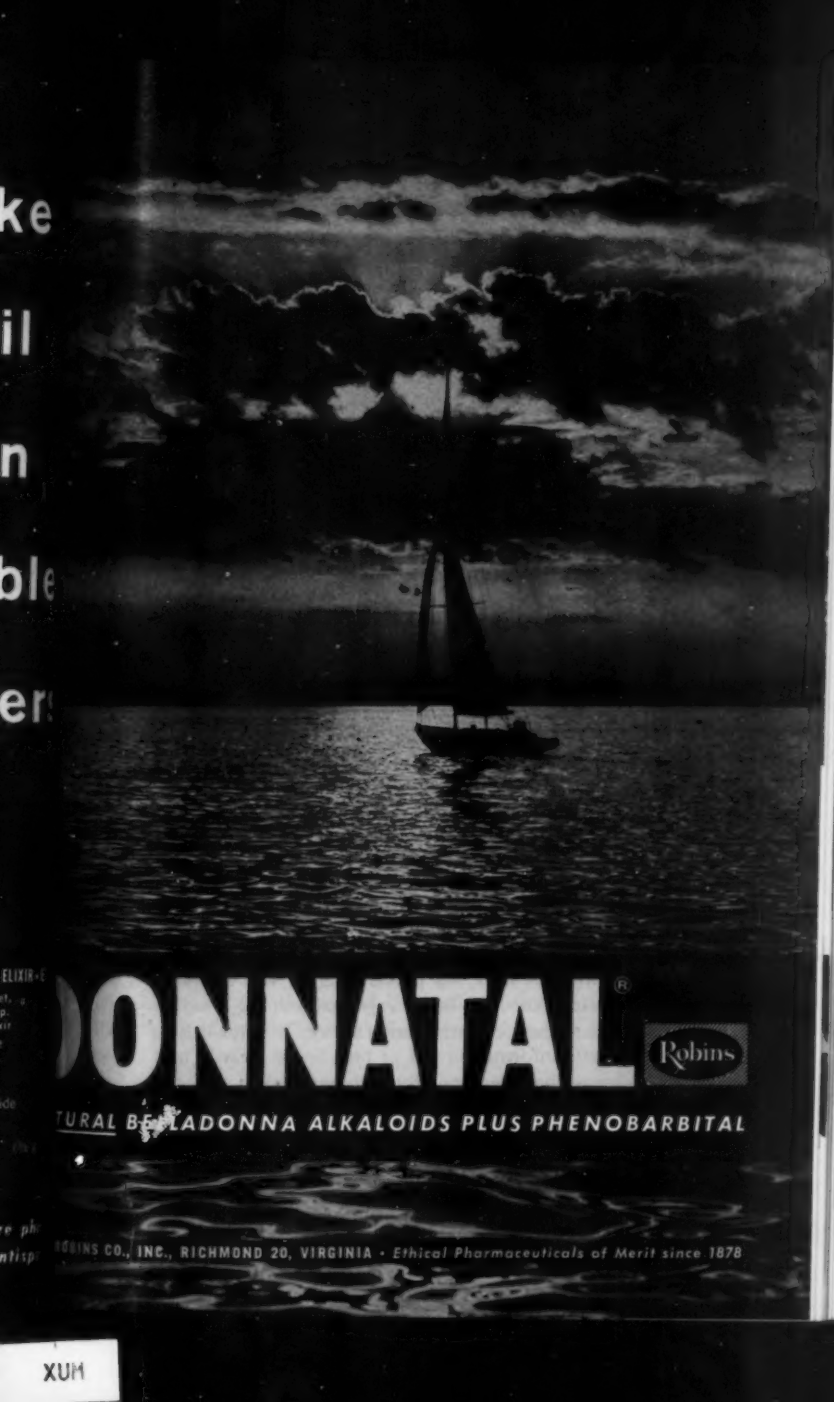
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In each Tablet, Capsule or tsp. (5 cc.) of Elixir

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pretty sure *you'd* rather not treat, either.

With that qualification out of the way, here are my methods:

Some Standard Excuses

¶ I may state that my patient-load won't permit me to take on anyone new. "I'd better be realistic, Mrs. Jones," I may say. "The way things are now in my office, it looks as if I just won't have the time to give your problem the thorough attention it should have. This being so, it would be unfair to accept you as a patient. But I can give you the names of several good doctors . . ."

¶ I may say it would be good for the new patient to have a physician with a more conveniently located office. "I think it wou be better all around," I'll t Mrs. Jones, "if you were und the care of a doctor who's clos to your home. It would be eas for you. And, as you know, i also a wise precaution in case o an emergency. Now, there a several good doctors with offic near you . . ."

¶ I may have my aide spell o a payment policy that will sca off a potential deadbeat rig away. "I'm very sorry, Mr Jones," my aide may say, "bu the policy of this office has a ways been that payment be ma when the service is rendered. O course, once you have becom an established patient . . ."

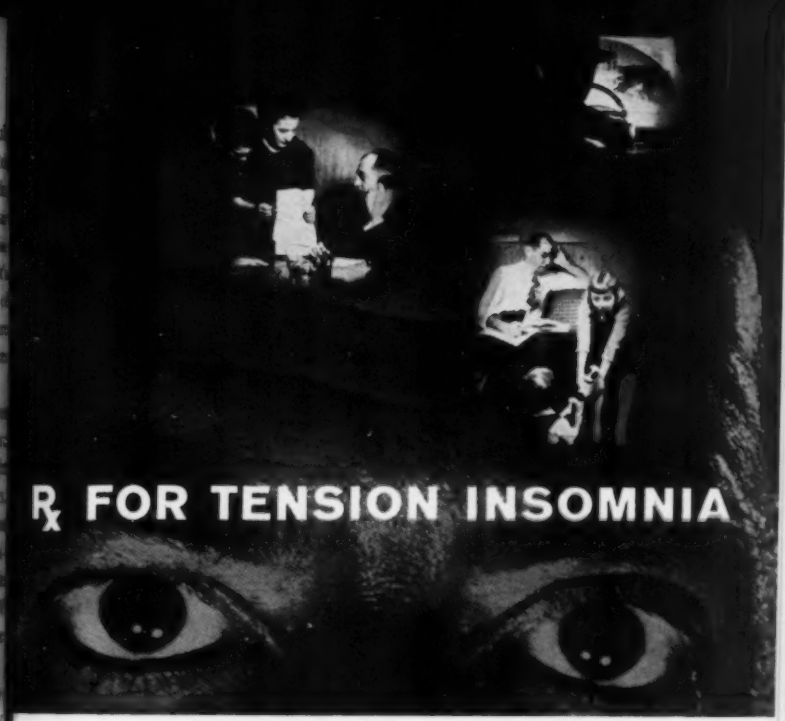
¶ I may plead a limited pra tice. "Mrs. Jones, I'm somewh

Love, honor, and OB

The exhausted OB/Gyn. resident finally got to bed at 3 A.M. Ten minutes later, his phone rang. It was a clinic OB patient. It seemed she had a vague pain in the lower abdomen and a slightly elevated temperature. Beyond this he could get little information out of her. So he wearily told her to come to the emergency room to be checked.

"Oh," she said, "I'm afraid I can't do that. You see, I don't drive, and I wouldn't dare wake my husband."

—ANGELO CORDANO, M.D.



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- **insure alert awakening**
- **insure a tranquil mind and relaxed body**

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APAP (N-acetyl-p-aminophenol) ..... 325 mg.

Dosage: One Tussagesic tablet in the morning, mid-afternoon and evening, if needed.

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embarrassed to tell you this," I'll begin, "but just recently I've begun to limit my practice, and since your particular problem is outside my field . . ."

No Smoke Screen

¶ Finally, when a patient and I don't hit it off, I can always use a direct approach. And on occasion I do. I simply tell a patient in this situation that we'd be better to part company. Thus:

"May I be frank, Mrs. Jones?" I'll begin. "As you know, it's very important that there be an excellent patient-physician relationship. Even with good intentions, one can't force that kind of thing. I feel we both realize such a relationship doesn't exist between us. Since it doesn't, I'd like you to feel free to engage another physician. There are several I might recommend . . ."

To turn away patients may be unorthodox. But it's both ethical and practical. And it helps me practice better medicine.

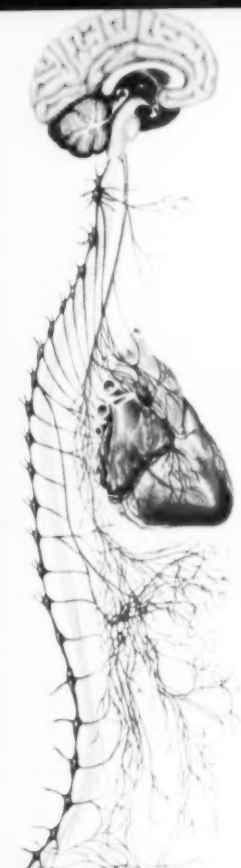
Remember, every time I weed out an unwanted patient, I free some time and energy for a desirable patient. In my book that's a patient who's cooperative, who's financially dependable, who's serious about wanting *me* as his physician. In short, a patient who deserves my best. END

Sleepy . . . sleepier . . . asleep! Placidyl's light touch does the trick. Brief. Effective.
Not a barbiturate. Your patients sleep soundly, wake next morning refreshed. Put Placidyl to work in your own practice, soon.



Placidyl® nudges your patient to sleep

(Ethchlorvynol, Abbott)



and the evidence mounts

In two recent studies, involving 179 mixed anxiety and hypertensive patients—Harmonyl produced far less lethargy and listlessness than Reserpine—and yet with comparable potency and effectiveness.

Below, two charts taken from these reports dramatically illustrate the exceptionally low incidence of side reactions with Harmonyl.

RESULTS OF "DOUBLE-BLIND" STUDY OF 99 MIXED ANXIETY AND TENSION PATIENTS[1]

Side Effects	Tablet A Deserpidine 43 patients	Tablet C Placebo 24 patients	Tablet C Reserpine 27 patients
DIZZINESS	0 (0%)	3 (12%)	4 (15%)
DRYNESS OF MOUTH	3 (7%)	1 (4%)	6 (22%)
BIZARRE DREAMS	0 (0%)	2 (8%)	7 (26%)
LISTLESSNESS	1 (2%)	4 (17%)	9 (33%)
DETACHMENT (Diminished awareness)	0 (0%)	0 (0%)	2 (7%)
ANOREXIA	1 (2%)	3 (12%)	4 (15%)
WEAKNESS, TIREDNESS, NO PEP	0 (0%)	8 (33%)	16 (59%)
DAYTIME SLEEPINESS	1 (2%)	4 (17%)	19 (70%)
HEADACHE	0 (0%)	18 (75%)	4 (15%)
NAUSEA	0 (0%)	2 (8%)	3 (11%)
ABDOMINAL CRAMPS	1 (2%)	4 (17%)	5 (18%)
RASH	0 (0%)	0 (0%)	0 (0%)
NASAL STUFFINESS	1 (2%)	0 (0%)	4 (15%)
LOOSE STOOLS	0 (0%)	1 (4%)	3 (11%)

Percentages supplied by Abbott Laboratories.

Author's Comments: "With deserpidine there was less abrupt hypotensive action on blood pressure than with reserpine, and less fatigue or sleepiness during the day."

COMPARISON OF SIDE EFFECTS IN 80 HYPERTENSIVES TREATED WITH VARIOUS FORMS OF RAUWOLFIA[2]

Side Effects	Reserpine	Alseroxylon	Deserpidine	Rescinnamine
LETHARGY	11	10	1	1
NASAL OBSTRUCTION	10	8	8	2
DREAMS	8	7	3	1
ACHING	8	7	3	0
DEPRESSION	3	3	0	1
DIARRHEA	2	3	1	0

Author's Comments: "Deserpidine when given in the morning, showed a definitely lower incidence of lethargy, and depression was not encountered in any patient."

Harmonyl®

(Deserpidine, Abbott)

for your next working hypertensive

ABBOTT

1. Frohman, I. P., Tranquilizers in General Practice and Clinical Evaluation of Deserpidine, an Aklaloid of Rauwolfia, Canescens, M. Ann. District of Columbia, 27:641, December, 1958.

2. Winsor, T., Comparative Effects of Various Rauwolfia Alkaloids in Hypertension, Diseases of the Chest, April, 1959.

908050



Which Bills Should You Give to a Collector?

Accounts that have gone unpaid for five months may be worth turning over to an outside agency. But before you turn them over, give them this test

By Arthur Owens

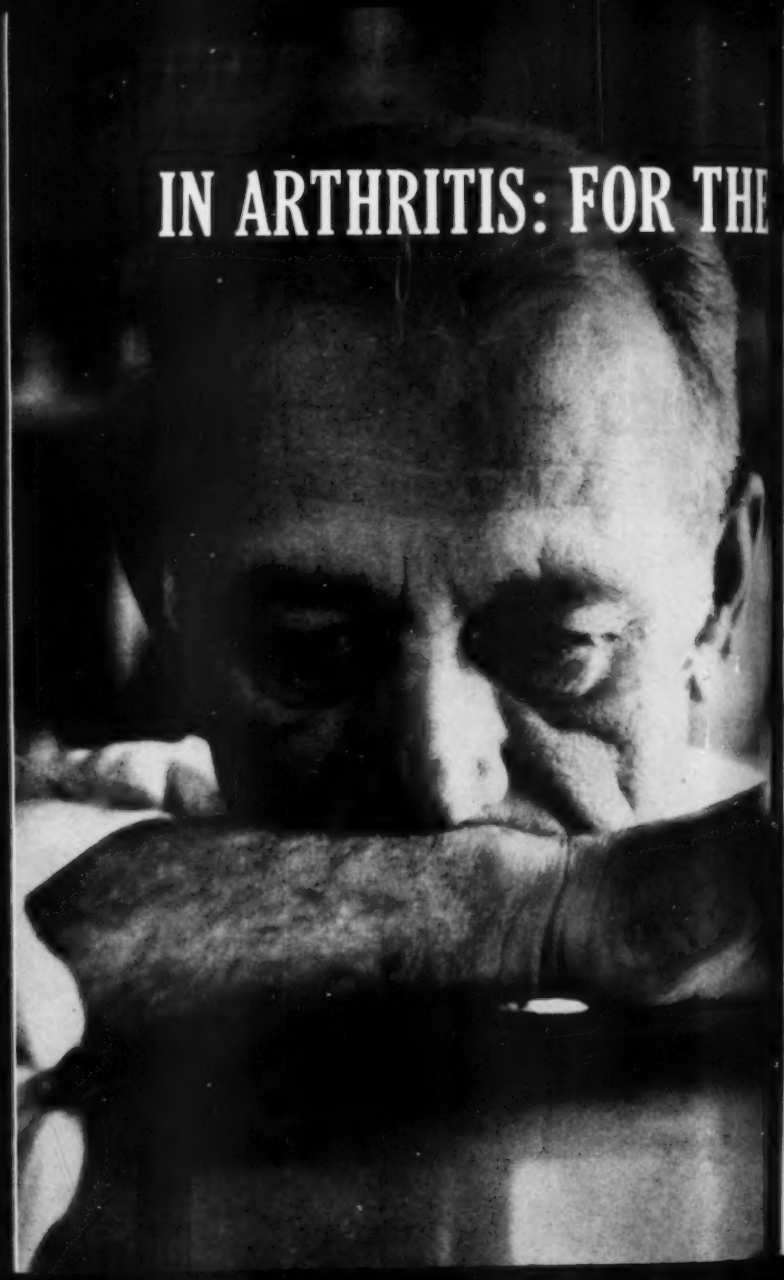
If you send an unpaid account to a collection agency too soon, you waste money and risk antagonizing the merely dilatory patient. But if you wait too long, the bill becomes more difficult—and more expensive—to collect.

At what point, then, should you think seriously about calling in a collector?

The fees of most collection agencies are higher after the sixth month. An agency that charges $25 to collect a five-month-old bill of $100 will often increase its fee to $33.33 a month later. So it's smart to consider calling in a collector when the bill is five to six months old.

Actually, though, the age of an unpaid account is only one criterion for judging whether to give it to a collection bureau. When there's been no action on a delinquent account for five to six months, think about turning it over to an agency *only* if it's ripe.

How do you decide whether


IN ARTHRITIS: FOR THE

THE FEAR AND THE AFFLICTION



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Proved clinical record in corticosteroid therapy · Tranquilizing and muscle-relaxant effects[1] of hydroxyzine enhance prednisolone efficiency · Often permits lower corticoid doses[2-4] · Antisecretory action[5] of hydroxyzine minimizes gastric side effects

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1. Hutcheon, D. E., et al.: Paper presented at Am. Soc. Pharmacol. & Exper. Therap., Nov. 8-10, 1956, French Lick, Ind. 2. Johnston, T. G., and Cazort, A. G.: Clin. Rev. 1:17, 1958. 3. Warter, P. J.: J. M. Soc. New Jersey 54:7, 1957. 4. Individual Case Reports to Medical Dept., Pfizer Laboratories. 5. Strub, I. H.: To be published.

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it's ripe to go to an agency? By considering whether or not you've taken these preliminary steps:

1. You've sent the bill to the person who's responsible for paying it. Suppose, for example, your patient is the minor child of divorced parents; and suppose your aide has been dunning the wrong parent. Such mistakes aren't at all infrequent.

Take the advice of collection specialists: Make certain that your secretary records the name and address of the person responsible for the bill for each new patient. And if there's any doubt about the legal debtor for an unpaid account, check on it before giving up your own efforts to collect.

2. You've seen to it that the patient understands all charges. If he doesn't, he may be withholding payment simply because he thinks them excessive. This can easily happen if you make extra charges (e.g., for X-rays, laboratory work, or consultation) without itemizing them. To avoid misunderstandings, it's obviously wise to get the patient's consent in advance for such special procedures.

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Easy for mothers . . . just add water



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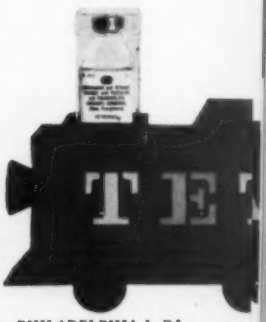
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AND FOR THOSE WHO CAN'T "TAKE" MILK... *MULL-SOY*

SIMULTANEOUS IMMUNIZATION AGAINST 4 DISEASES:

Poliomyelitis-Diphtheria-Pertussis-Tetanus

. . . is now possible



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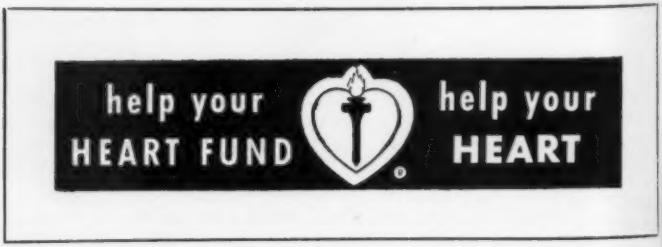
3. You've investigated the debtor's ability to pay. Doctors with the best collection records establish such ability at the time of treatment. In cases of temporary inability to pay (because of unemployment, for example), these doctors continue billing monthly for at least six months. Meanwhile, they encourage the patient to set a probable date for payment. If at that time he's demonstrably on his feet again and still refuses to pay, they consider turning the account over to an agency.

Of course, there are always a few deadbeats. If you suspect a debtor of being one, you can often get an impartial appraisal of his ability to pay from the local affiliate of the Associated Credit Bureaus of America. For three or four dollars, the A.C.B. member will give you a quick report on the delinquent's payment record; his bank accounts; his history of suits and judgments, if any; and his income.

4. You've sent your bills promptly and regularly. Two or three months after the date of your first statement (or the patient's last part-payment), it's a good idea to send him a delinquent notice. If this doesn't get esults within a month, have your secretary write him at fifteen-day intervals. Object: to obtain either a promise to pay or an explanation of nonpayment.

His Last Chance

If there's still no action by the fourth or fifth month, it's probably high time to mail a "final notice." The patient is now warned that payment is expected within, say, ten days. And he's given to understand that if he doesn't comply, your auditor (not you) insists that the account be put in



SIMULTANEOUS IMMUNIZATION
AGAINST 4 DISEASES:
Poliomyelitis-Diphtheria-Pertussis-Tetanus

...now immunization is possible against—



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the hands of a collection agency.

5. You've tried to trace the debtor who has apparently disappeared. It's worth a few phone calls to save the extra charge agencies make for locating "skips." Your aide should get in touch with at least some of these possible sources of information: the missing individual's former landlord; his last employer; his closest relative; and the person, if any, who referred him to you.

6. You've made reasonably sure that there's no chance of a malpractice suit. Says one experienced collector: "If the patient has threatened such a suit, it's best to withhold collection pressure until the statute of limitations* has run out—regardless of whether the facts warrant such a suit."

*Generally, the statutory limit on malpractice suits is shorter than the statutory limit on suits for nonpayment of bills. The former is often two or three years; the latter, longer than that. But since state laws vary, better check locally before turning over a borderline account to an agency.

How to Test Your Own Collection Efforts

If you believe you've made a thorough and conscientious effort to collect a long-overdue bill, you can think seriously about turning it over to an agency. But before actually doing so, take time to double-check your collection efforts. Ask yourself the following questions:

¶ Do I know who's responsible for the bill?

¶ Does he clearly understand all charges?

¶ Am I sure he *can* pay now? Have I offered him a chance to pay at a later date, if he seems to need more time?

¶ Has my office mailed regular monthly statements and followed them up with letters or phone calls and then with a "final notice"?

¶ If the debtor has moved, have I tried to trace him?

¶ Is there a chance of a malpractice suit if I press for payment?

Only if all six signal lights have turned green should you turn the account over to a collector. END

SIMULTANEOUS IMMUNIZATION
AGAINST 4 DISEASES:
Poliomyelitis-Diphtheria-Pertussis-Tetanus

...now immunization is possible against more diseases—



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More $150,000 Malpractice Verdicts

Continued from 86

wife who's not earning a penny can be evaluated through expert testimony at a minimum of $120,000, then what's in store for doctors? Probably even bigger verdicts in cases involving the man of the house!

When I mentioned this to Justice Doscher, I was a bit surprised at the vehemence of his response: "There's no doubt there's an uptrend in the size of awards. And let me tell you something else. I've been on the bench of the Supreme Court since 1951. Never in all that time have I seen so many malpractice actions as I have in the past twelve months. People are certainly more suit-conscious."

"Would you say that this $150,000 verdict will encourage more people to sue doctors in similar circumstances?" I asked.

"I suppose it will," said Justice Doscher. "But I'd like to make it plain that I don't think doctors are being singled out. Claims and verdicts are going up in all personal injury cases, not just malpractice cases.

"The courts aren't picking on doctors. If there are unjustified suits, they're exposed soon enough in court. We're not unsympathetic to the doctors' plight. I have a son who's in his third year at New York Medical College right now."

"But if we're going to get more six-figure awards, and if this pattern emerging through expert testimony means we'll get even higher ones, what can the doctor do about it?" I asked.

Food for Thought

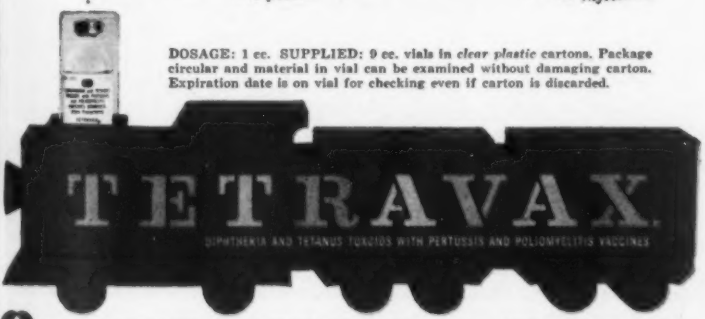
"I don't think there are any easy answers to that question," replied Justice Doscher. "But here's something for doctors to think about: I've never yet had a family doctor in my court as a defendant in a malpractice case. Perhaps it's because family doctors refer more of their difficult cases to specialists. Perhaps it's because they establish a sounder, closer relationship with their patients. Perhaps, too, they're franker with patients about their mistakes. I can't pinpoint the reason. But it's worth thinking about. Don't you agree?"

I agreed. END

SIMULTANEOUS IMMUNIZATION AGAINST 4 DISEASES:

Poliomyelitis-Diphtheria-Pertussis-Tetanus

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Inside the Ochsner Clinic

Continued from 96

In line with this kind of thinking, every room in the hospital's pediatric section has an extra bed for the mother who wants to stay with her child. The emphasis on the patient's well-being explains why the 250-bed hospital has a staff of 109 R.N.s, seventy-five aides, and twenty-four orderlies. And it also explains the reason for Brent House.

Brent House was built as a comfortable "motel" adjacent to the hospital. Here, patients' families could get bed and board at moderate prices. They still can. But Brent House has also evolved into a pioneer establishment for progressive medical care: a convalescent facility for ambulatory patients.

Such a set-up costs plenty of money. But I talked to a good many clinic doctors without hearing a murmur against the expense. The $5,500,000 Ochsner Foundation Hospital isn't just a show place. It's a doctor's dream

How Much Does the Ochsner Clinic Charge?

Medical and surgical fees at New Orleans' famous medical group are moderate. A medical visit costs $6; a consultation, usually $10. If the patient's insurance policy has a $300 surgical schedule, his surgical bill is likely to be fully covered. But in spite of low unit cost for each doctor's work, the fee for a full-fledged clinic check averages between $150 and $200.

Even with lavish personal service, the Ochsner Foundation Hospital charges only $15 a day for a semiprivate room. But X-ray and laboratory fees bring the total charge to more than double that amount for the average patient. Reason: A high percentage of cases are referred for difficult diagnostic problems and major procedures.

Dosage: 2 Tablets B.I.D. (A.M. & P.M.)

[redacted]

in premenstrual tension only neo Bromth® treats the whole syndrome





It was the introduction of neo Bromth several years ago that created such widespread interest in the premenstrual syndrome—because of neo Bromth's specific ability to prevent the development of the condition in the first place.

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neo Bromth is completely free from undesirable side effects associated with such limited-action therapy as ammonium chloride, hormones, tranquilizers and potent diuretics. neo Bromth remains the safest—as well as the most effective—treatment for premenstrual tension.

Each 80 mg. tablet contains 50 mg. Pamabrom, and 30 mg. pyrilamine maleate. Dosage is 2 tablets twice daily (morning and night) beginning 5 to 7 days before menstruation. Discontinue when the flow starts.

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of the kind of shop he wants to work in.

"I can do three times the work here that I could in any other hospital," says Dr. Ochsner. The day he talked to me, he'd done two thyroidectomies, a colon resection, a pneumonectomy, and a gallbladder—and had started his afternoon office hours on time. "We get things done because we're organized right," he told me.

Having the place "organized right" means that while a surgeon is working on one patient, the previous patient is in the recovery room sleeping it off under the watchful eye of a nurse. And the next patient is in the anesthesia induction area, getting ready to be wheeled into a fresh operating room. The surgeon moves from one operating room to the next like a guest at the Mad Hatter's tea party.

Such efficient organization is the rule in every branch of the Ochsner empire. As a result, the doctors are singularly blessed by being released from a number of mundane and annoying problems. For instance:

The insurance department

in pregnancy...
hydrocholeresis plus reliable spasmolysis

relieves biliary dyskinesia and functional G.I. distress...
natural laxation without catharsis

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WITH BELLADONNA *one tablet t.i.d.*

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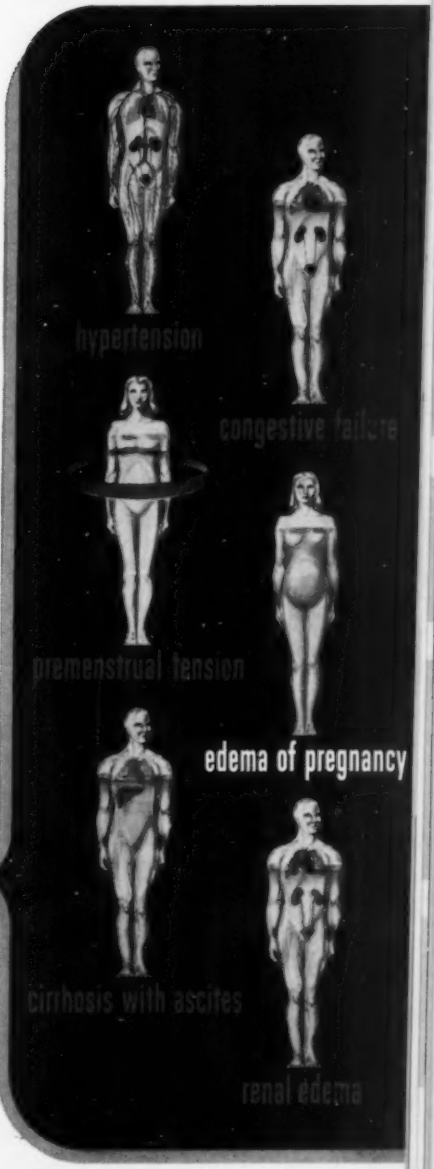
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Assali, N.S., Judd, L.J. and Mondz, N.: J.A.M.A. 169:26, (Jan. 3) 1959.

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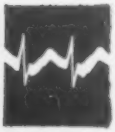
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"nutrition...present as a modifying or complicating factor in nearly every illness or disease state"[1]

the rationale fo

in cardiac disease



"B vitamins should be an integral part of the treatment prescribed for any patient with cardiac disease....As a consequence of special low salt diets and diuretics prescribed to release the water held in the body fluids by an excess of sodium, the B vitamins are 'washed out' of the body with the salt, and the difficulties of the disease are compounded."[2]

Each Theragran *supplies:*

Vitamin A	25,000 U.S.P. units
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Thiamine Mononitrate	10 mg.
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Dosage: 1 or more daily as indicated.

Supply: Family Packs of 180. Bottles of 30, 60, 100 and 1,000.

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Also available: Theragran Liquid, bottles of 4 ounces; Theragran Junior, bottles of 30 and 100.

in infectious disease



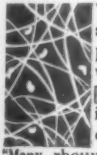
"There are ample, critical, statistically significant studies to indicate that good nutrition is important for optimal resistance to infection, for a superior tissue capability to cope with disease and injury, and for maximum antibody formation."[3]

"Fever also increases vitamin requirements. This is especially true of B-complex and C vitamins. Liquid and soft diets, which are commonly prescribed early in disease, are inadequate in these vitamins. It is advisable to give supplementary vitamin capsules during the actual illness and convalescence."[4]

References: 1. Youmans, J. B.: *Am. J. Med.* 25:659, Nov. 1958. 2. Gertler, M. M.: Paper presented at Conference on Metabolic Factors in Cardiac Contractility, N. Y. Acad. Sciences, New York City, N. Y., March 18-19, 1958. 3. Fernandy-Herlihy, L.: *Lahey Clinic Bull.* 11:12, July-Sept. 1958. 4. Spies, T. D.: *J.A.M.A.* 167:675, June 7, 1958. 5. Halpern, S. L.: *Ann. N. Y. Acad. Sci.* 3:147, Oct. 28, 1955. 6. Pollack, H., and Halpern, S. L.: Therapeutic Nutrition, National Academy of Sciences and National Research Council, Washington, D. C., 1952, p. 54. 7. Kountz, W. B.: *Mod. Med.* 25:102, Aug. 1, 1957. 8. Sebrell, W. H.: *Am. J. Med.* 25:673, Nov. 1958.

The use of vitamins

in rheumatoid arthritis



"It is our practice to prescribe a multiple vitamin preparation to patients with rheumatoid arthritis [collagen disease] simply to insure nutritional adequacy..."[3]

"Many rheumatologists now look for nutritive failure among the patients who have arthritis and other debilitating diseases."[4]

in degenerative disease



"Most degenerative disease changes are believed to be related to disturbed nutrition.... Even though blood levels may be adequate [for vitamin A, vitamin D, thiamine, ascorbic acid, and riboflavin]... many individuals will improve with supplementary administration."[7]

"In chronic diseases... in which there is a loss of appetite, difficulty in eating or abnormal metabolic demand, symptoms of B vitamin deficiencies also have been found frequently and should always be looked for in their management."[6]

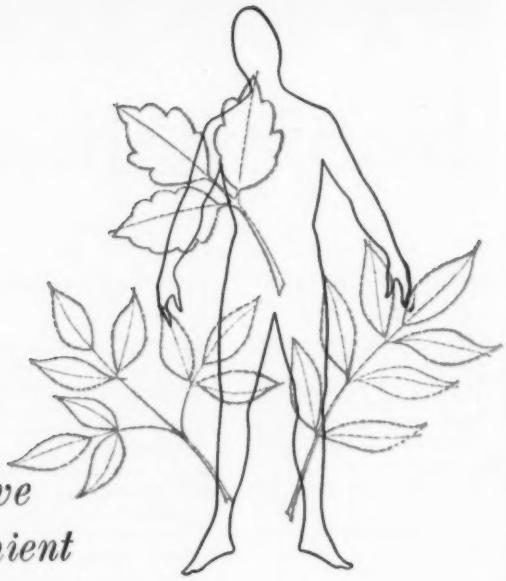
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Topical Ointment

A rational approach to the control of dermatoses because of its dual effectiveness against both infection and inflammation. In a specially formulated, easily applied ointment base.

Supplied: In 1/6-oz. and 1/2-oz. tubes, containing 3% oxytetracycline hydrochloride (Terramycin*) and 1% hydrocortisone (Cortril*).
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fills out all insurance forms. The stenographic pool types every physician's many conscientious letters and reports to referring doctors. The billing department collects the fees. (There's a list of usual charges for each procedure. So the doctor can practice medicine without letting the dollar sign cross his mind. But he's also free to vary the fees if he feels they should be scaled up or down.)

Method of Compensation

Finally, the Ochsner man is relieved of some personal financial worries that bedevil doctors in more competitive situations. He begins work for the clinic as a salaried junior man. At the end of five years, if things work out, he's invited to join the partnership. At this point, he must raise $1,000 in order to buy in. And for the next several years he must accept rather less than a full share of the partnership's earnings. But once he's in, the practice is as much his as anybody's.

Furthermore, he has malpractice insurance premiums paid, for high limits. His medical society dues are paid for him. He gets $10,000 worth of life insurance. And he stands to benefit from a generous pension plan.

The Ochsner Clinic runs so smoothly that you might think it had been running forever. Yet the big enterprise began only eighteen years ago as a five-man partnership. The founders—Drs. Alton Ochsner, Guy Caldwell, Curtis Tyrone, Edgar Burns, and Francis LeJeune— retained full control for some years. But after they found that the younger men were unhappy about not having a voice in the clinic's management, they decided to give their juniors a right to buy in. *More*▶



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- produces natural, soft, well-formed stools.
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Don't Overlook Closed-End Investment Firms

Continued from 79

Should *you* put some money in a closed-end company? If so, should you look for shares that are selling at a discount and that therefore offer a chance for greater appreciation? Or should you buy shares that sell at a premium and that may therefore seem sounder, though less immediately profitable?

For the answers, you'll do well to ask your banker, broker, or investment counselor. In the table on page 76 you'll find a list of some of the leading closed-end issues, along with pertinent financial statistics. But there are plenty of other companies to choose from.

The final choice, if any, is up to you. END



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What to Do About Stock-Market Fever

Continued from 101

something from membership. I don't mean you'll become a stock market analyst. But you'll learn the jargon and some of the basic rules.

Finally, if you really want common stocks in your future, as distinct from a market flirtation to find out what all the other guys are talking about, get the proper kind of help. If you're going in for stocks in a big way, call in an investment counsel.

I don't mean a securities broker, though he's a fine fellow. I mean a man of reputation who makes his living advising individuals on their investments.

He charges you an annual fee. He doesn't personally handle your money or your stocks. He doesn't take commissions on the purchases and sales you make on his advice.

How much annual fee will he charge? It will probably be a percentage of the value of your portfolio. Five dollars per thousand is a common rate. But there are good men who'll settle for $3 per thousand. In addition, though, there are minimums. The lowest I know about is $150 a year, and it's more likely that you'll have to pay at least $250-$500.

Whatever you do, watch out for one big red light. It glows when The Wall Street Journal gets into your professional office. If you intend to remain a physician, better keep your financial weeklies, market letters, annual reports, and the rest of your investing impedimenta at home. Your investing ideas belong there too.

The day you find yourself talking I.B.M. and Texaco to a business-looking type as he sits on your examining table stripped to the buff, Doctor, you're a gone goose. END



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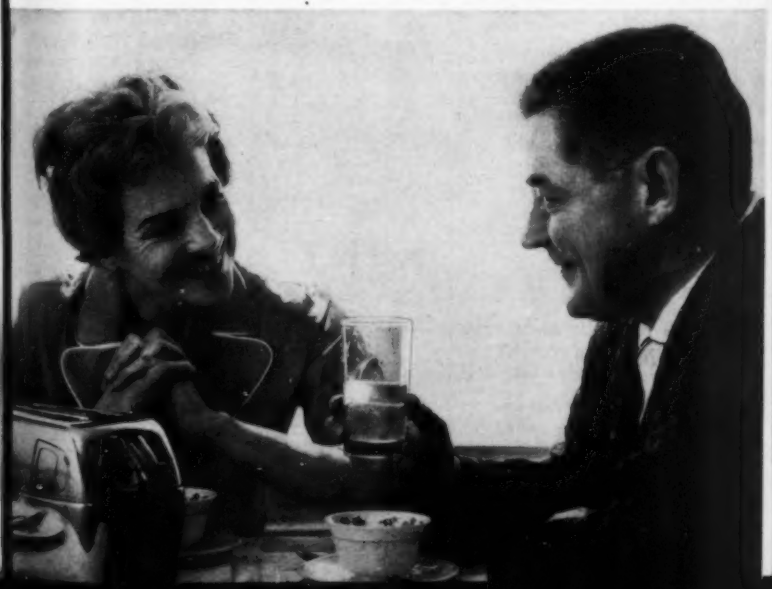
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1. Greenhouse, B.: Ann. New York Acad. Sc. 74:643, 1959. 2. Dobson, H., et al.: Ibid., p. 940. 3. Forsham, P. H.; Magid, G. J., and Dorosin, D. E.: Ibid., p. 672. 4. Beaser, S. B.: Ibid., p. 701; New England J. Med. 259:573, 1958. 5. Bloch, J., and Lenhardt, A.: Ann. New York Acad. Sc. 74:954, 1959. 6. O'Driscoll, B. J.: Lancet 2:749, 1958. 7. Hadley, W. B.; Khachadurian, A., and Marble, A.: Ann. New York Acad. Sc. 74:621, 1959. 8. Duncan, G. G.; Schless, G. L., and Demeshkieh, M. M. A.: Ibid., p. 717. 9. Handelsman, M. B.; Levitt, L., and Calabretta, M. F.: Ibid., p. 632. 10. Hills, A. G., and Abelove, W. A.: Ibid., p. 845. 11. Drey, N. W., et al.: Ibid., p. 962.



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During the past year, Kent sales increased by 20-billion cigarettes—the greatest gain in popularity ever recorded by any filter cigarette in any year.

Undoubtedly much of the credit for this important rise in sales must go to Kent's exclusive "MICRONITE" Filter. This extraordinary new filter was constructed to take into account new principles of filtration which were dictated by the basic discoveries of a major research foundation, working under Lorillard sponsorship.

The foundation determined that the average puff of cigarette smoke contained over 12 billion semi-solid particles. Additional research revealed that inhaled smoke from ordinary cigarettes has a predominant proportion of particles, from 0.1 to 1 micron in diameter, average 0.6 micron.

Ordinary filter fibers are so large that they create spaces through which the small semi-solid smoke particle can easily pass. However, in the exclusive Kent filter, the fibers are mechanically manipulated in such a manner as to create extremely tortuous passageways for the smoke. In this maze-like network of superfine fibers the smoke particle has much less chance to slip through the filter.

Thus, Lorillard research created a filter which reduced tars and nicotine in the "inhaled" smoke to the lowest level among the largest selling brands. As smokers learned about the "MICRONITE" Filter, they changed to Kent. During the past year, for instance, more smokers changed to Kent than to any other cigarette in America.



If you would like for your own use the booklet, "The Story of Kent," write to: P. Lorillard Company Research Department 200 East 42nd Street New York 17, N.Y.

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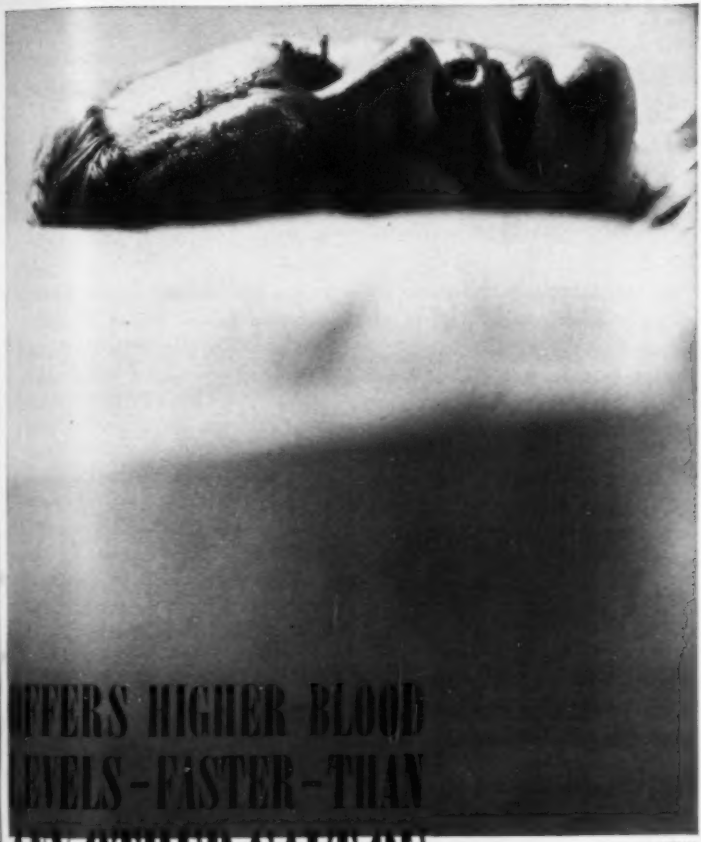
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